Department of Behavioral Health

DBH Information Technology — Education — Communication — Service

SIMON MHS REFERENCE MANUAL

Simon MHS Selection Menu

InSyst Main Menu

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FUNCTION KEYS (DEFINITIONS)

The" Num Lock" and "Control" keys are often referred to in this manual. The "Num Lock" Key and "Control" keys can be used in conjunction with other keys to perform many functions. To use the Num Lock key press the Num Lock key, **release it**, and then press the next key. To use the Control key you hold down the Control key **while** you press the next key.

Num Lock Keys:

NL-A   (Additional Authorization) Use this to request additional functions in entry and maintenance screens. It invokes Supervisor Mode in the Episode Update Screen and allows updating of additional Fields. In the Single Service Entry screen it allows Late Entry and Supervisor Mode. In other screens it provides additional functions.

NL-B (back)   This causes the screen to "page" backward one page

NL-C   (Client Number) Moves the cursor to the Client Number field to allow entry of a new client number. This function is not always available. In general, it is available prior to the validation of a client number and the displaying of information on the screen.

NL-E (exit)   Use this to exit from the current screen and <enter> to the previous menu. NumLock-E does not retain any values from the current screen.

NL-F   (Displays template) This sequence displays a Menu at the bottom of your screen for Function Keys F6-F12. For example, if you press the F6 Key it will print a "Face Sheet" if a Client's information is on the screen when the menu is displayed,

NL-I (insert)   This sequence is used to invoke "insert" Mode from Maintenance Selection Screens. In the Client Messages Screens it allows you to insert a new client Message while you are reviewing other Client Messages. If you have selected a Client Message for review and decide that you would like to enter a new message for the client, press the key sequence Num Lock-I, and the screen will split into two windows to allow you to enter a new message while the old message is still displayed on the screen.

NL-M (more)   This sequence causes the screen to "page" forward. Often, more information is available than can be shown on the screen at one time. The information is stored in "screen pages." The information can be viewed in "pages". Num Lock-M displays the next page of information.

NL-R (refresh) This sequence restarts the screen. If you make a mistake or wish to restart the current screen, use Num Lock-R. The screen is restarted with no values entered.

NL-S (save)   Use this sequence to leave a current data entry or maintenance screen. This allows you to leave the screen and retain the current Client and Reporting Unit information. When you select the next data entry or maintenance screen, the screen automatically displays the relevant data for the "saved" client and reporting unit.

Control Keys:

Control / W (repaints) This combination repaints or refreshes the screen. For instance, if you receive unusual characters on you screen as a result of communication problems, and the current screen presentation is disrupted, the screen can be repainted by using the Control /W combination. The screen is refreshed with all of the present values that have been entered.

Control / H (backs up one field)   This combination backs up the cursor one field.

Control / J (clears a field)   This combination clears only the field where the cursor is located.

Control / Z (ends an editing session) This ends an editing session in mail, files, and client message utilities.

Log In

```
Having trouble, please contact: ISD HELPDESK  (909) 884-4884
                  or e-mail isdhelpdesk@isd.sbcounty.gov
Website www.sbcounty.gov/dbh or Intranet http://countyline/dbh


     Unauthorized access is prohibited. Violators WILL be prosecuted.


               IMPORTANT SYSTEM NOTICE
       Print Queues will be emptied every Friday at 2:30pm.
   If you have any questions or difficulties please contact the HELPDESK.




Username: yes_u
Password:
```

1. Username: Type "last name_first initial" (XXXXX_X) <Enter>
2. Password: Type "newpass" <enter> You will not see the text! <Enter>
3. This password will expire immediately.
4. Type the password you seleted <Enter>
5. Type the password again for verification. <Enter>

The password must be a minimum of 7 characters, maximum of 32. The system will not allow any reuse of passwords. The system dictionary of contains 2,000 commonly used passwords and the system will **NOT** allow you to use any one of those words.

SOLUTIONS: Use two small words together with no space. Use alpha and numeric characters. Use a very creative word. When you have signed on the system there will be two message screens that you will press enter to go past to get to the Main Menu.

MAIN MENU

You can select from the Main Menu one of the following:

1. Mental Health
2. Drug and Alcohol
3. Utilities

To make the selection*:*

Type **MH** or **1** or tab and place an "**x**" next to **MHS** for Mental Health.

DA or **2** or tab and place an "**x**" next to **DAS** for Drug and Alcohol.

UT or **3** or tab and place an "**x**" next to **Utilities** for Utilities.

This will take you to the MAIN MENU for the environment you want available.

```
          I n S y s t


       MAIN  MENU


   Selection:

      Selection      Description

      MHS            MHS Menus
      DAS            DAS Menus
      UTILITIES      General Utilities Menu


V─────────────────────────────────────V
```

THE CLIENT NUMBER

Clients need a distinctive client number before you can work in SIMON. If a client is new to your program, you must determine whether the client has ever been seen at another clinic within the SIMON system by using the Client Locator screen described below. If you cannot find the client number in MHS or DAS, assign a new client number using the Client Registration Screen.

Client Locator Screen
The Client Locator Screen lets you:

> • find out if someone has ever been a client
> • display a client's current episodes
> • display current financial status
> • determine if there are any current Client Messages
> • request a Face Sheet report for the client
> • jump to the Client Status Summary Screen
> • jump to the Account Status Summary Screen

Every client that has ever been to any San Bernardino County Behavioral Health clinic has a medical record number in "SIMON". Be alert for misspelled names, birth date errors, and some have no social security numbers.

When a client comes to a Behavioral Health clinic seeking services, the client's name is researched in the MHS and DAS client locator screens.

```
              Client  Locator  Screen

   ┌──────────────────────┬──────────┬──────────┬────────────┐
   │                  ▮  ▮ │          │      N   │
   │ Last Name      First Name    Clt Idx No.   Soundex       │
   ├──────────────┬───────────────┬────────────┬─────────────┤
   │              │ 000-00-0000   │            │             │
   │ Client Number  Social Security No.  Account No.   Other ID │
   └──────────────┴───────────────┴────────────┴─────────────┘



   ┌──────────────────────────────────────────────────────────┐
   │ ▌                                                          │
   │                                                            │
   │                                                            │
   └──────────────────────────────────────────────────────────┘

      Selection: ▮▮▮▮▮▮

   ┌─────────────────────────────────────────────────────────
   │▌ EPISODE       Mini Open Episode Status
   │  FINANCIAL     Mini Financial Status
   V─────────────────────────────────────────────────────────

   ▮▮▮▮▮▮ ▮            Confidential  Information        USER:
   Enter information for client location.
```

Clients that receive services from San Bernardino County Behavioral Health clinics have a medical record number in "SIMON". Be alert for misspelled names, birth date errors, and some have no social security numbers. **When a client comes to a Behavioral Health clinic seeking services, the client's name is researched in the MHS and DAS client locator screens.**
FROM THE MAIN MENU:
1. Select **CLIE**nt or **1** <enter>
2. Select **LO**cator <enter>
3. Enter name using steps A through G until client is found.
(using Num Lock-R to refresh the screen between searches)

a. **NAME CHECK**

Enter the client's last name, tab over and enter first name <enter>
A listing of 4 client names will appear; check names, birth dates, & social security numbers. Press Num Lock-M and 4 additional names will appear. You can view 8 names in all.

b. **LAST NAME CHECK ONLY**

Enter only the last name, the client might use a different first name. Check both pages of names.

c. **LAST NAME AND FIRST TWO LETTERS OF FIRST NAME ONLY**

Enter last name and only first two letters of first name. Check both pages of names.

d. **VARIATIONS OF NAME**

Enter all spelling variations of the last name, while using only the first 2 letters of the first name. Do the same thing using the middle initial in place of the first initial.

e. **MAIDEN NAME**

Enter the maiden name of the client as the last name.

f. **ALIASES**

Enter any aliases as the last name.

g. **MOTHERS NAME**

Enter mother's last name as the clients last name.

h. **NAMES WITH SPACES, HYPHENS, OR DASHES:**

• MC ANYTHING - (a space between MC and ANYTHING) will NOT bring up the name if it's in SIMON with no space between, e.g., MCANYTHING

• MCGUIRE - (no space between MC and GUIRE) will NOT bring up the name if it's in SIMON with a space, e.g., MC GUIRE.

• You must try the name both ways in the SIMON locator screen.

i. SPELLING VARIATIONS

• If the name is Speigle, with the soundex on (**soundex stays on until you turn it off**) try Speigle Spiegle Spiegel Speigel

j. **NICKNAMES:** Antonia – Toni   Elizabeth - Liz, Betty James – Jim John – Jack Margaret - Peggy, Maggie Thomas - Tom

IF ALL 8 CLIENTS ON THE SCREEN HAVE THE SAME COMMON NAME, E.G. SMITH, JOHN, USE THE Num Lock-A FOR UNLIMITED SCROLLING, USE Num Lock-M TO LOOK THROUGH THE
PAGES.

When you locate the client, "tab" down and put an "X" beside the correct name, press (<enter>) and the client information will be brought up to the boxes. NL-S will save the name and number so you can go to another screen to locate further information on that client. When you go to the new screen the client name and number will follow and appear on the screen, just press (<enter>) and the information for that screen will appear. **IF THE CLIENT CANNOT BE FOUND IN THE LOCATOR SCREEN**, this client is NEW to San Bernardino County Behavioral Health. The new client will need to be registered in the **CI**ent **RE**gistration Screen, which will issue the client a medical record number.

Last Name:	First Name:	M. Initial:	Maiden:

Alias (Other Name):	Home Phone:	Work Phone:	Date of Birth:

Sex: M F U	Age:	Soc. Sec. No.	Years of Education: (0-20)	Are you Pregnant?: Y N N/A

Marital Status: 1-Never Married   2-Married/Live together   3-Widowed 4-Divorced/Dissolved/Annuled 5-Separated 9-Unknown

Address (including City and Zip Code): (Homeless?   Y   N)

For Minors, Name of Parent/Guardian: Relationship: Phone:

In Case of Emergency, Notify (Name, Address, Phone):

Are you on Conservatorship?:   Y N   If so, Name of Conservator:

Health Care Insurance (check all that apply): ☐ Medi-Cal ☐Medicare ☐Blue Cross ☐Kaiser ☐Other HMO
☐ IEHP ☐Molina ☐ Healthy Families ☐Healthy Kids ☐ Other Insurance ☐None ☐Other

If Medi-Cal, your Medi-Cal No.:   County of Medi-Cal:

Employment: School:

Who Referred You?: ☐ Self ☐School ☐Probation ☐ DCS ☐CPS ☐Parent/Grd./Cnsrv./Fam. ☐ Prop. 36
☐Parole ☐Cal-Works ☐Court ☐AB2726 ☐AB2034 ☐Other

Services Desired: ☐Meds ☐Counseling ☐Help with Benefits ☐Drug/Alcohol ☐ Other

Have You Ever Been a Regional Center Client?: Y   N

Are you Seeking Services for Child Custody or Family Reunification?:   Y N

Were You Sent for Services by Probation or Parole or by the Court?:   Y N

Are You Seeking services Because of a Lawsuit or Charge Against You?: Y N

Are You Currently in Mental Health or Alcohol/Drug Treatment?:   Y N   Where?:

Caregiver: No. of children less than 18, client cares for?:	No. of dependent adults cares for?:

Special Population Code:
A = Assisted Outpatient Treatment service(s) (AB 1421)
C = Individualized education plan (IEP) required service(s) (AB 3632)
G = Governor's Homeless Initiative (GHI) service(s)
N = No special population service(s)
W = Welfare-to-work plan specified service(s)

Explain Why You are Here and the Help that You Would Like:

Describe Alcohol and Drug Use (and Problems):

Date: Printed Name of Person Filling Out This Form:

INITIAL CONTACT FORM	**CLIENT NAME:**
San Bernardino County	
DEPT. OF BEHAVIORAL HEALTH	**CHART NO.:**
Confidential Pt. Info.	
See W&I Code 5328	**DOB:**
	PROGRAM:

D R A F T

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Physical Disability: (please circle all that apply)

01 = Blindness or severe visual impairment
    02 = Deaf or sever hearing impairment
    04 = Speech Impairment
    08 = Physical impairment – mobility related
    16 = Developmental disability (ie., epilepsy, cerebral palsy, mental retardation, etc.)
    32 = Other, physical impairment, or disease not listed above (ie., loss of upper limbs, diabetes, hypertension, cancer, drug addiction,
        alcoholism, etc.)
    99 = unknown

Primary Language: _____   Preferred Language: ___

A = English	K = Cantonese	U = Polish	9 = Unknown/Not Reported
B = Spanish	L = Korean	V = Russian	
C = Chinese Dialect	M = Mandarin	W = Portuguese	
D = Japanese	N = Armenian	X = Italian	
E = Filipino Dialect	O = Llacano	Y = Arabic	
F = Vietnamese	P = Mien	Z = Samoan	
G = Laotian	Q = Hmong	1 = Thai	
H = Cambodian	R = Turkish	2 = Farsi	
I = Sign Language	S = Hebrew	3 = Other Sign	
J = Other	T = French	4 = Other Chinese	

Ethnicity (CSI = Race) with which You Most Identify: (up to 5 can be entered) _____ ___ _____ _____ _____

A = White	H = Vietnamese	L = Filipino	R = Samoan
B = Black	I = Laotian	N = Other Non White	S = Asian Indian
C = Native American	J = Cambodian	O = Unknown	T = Hawaiian Native
G = Chinese	K = Japanese	Q = Korean	U = Guamanian

Hispanic Origin = Ethnicity
Y = Yes
N = No
U = Unknown

Mother's First Name: Client Birth Name:

Birthplace: County: State: Country:

Significant Other's Name: Relationship: Phone:

Significant Other's Address:

Employment: (circle one)
1-Full Time	8-School	15-Not in Labor Force
2-Part Time	12-Unemployed (looking)	16-Unknown
4-Homemaker	13-Unemployed (not looking)	

INITIAL CONTACT FORM   **CLIENT NAME:**
    San Bernardino County
DEPT. OF BEHAVIORAL HEALTH   **CHART NO.:**   DRAFT
    Confidential Pt. Info.
    See W&I Code 5328   **DOB:**

                            PROGRAM:

CLIENT REGISTRATION

Once you have determined that this client is new to DBH, you must register the client to get a new medical record number. *If client is located in DAS read "Transfer Client Number From DAS to MHS" section (page 14) before proceeding with registration*.

ONLY NEW CLIENTS NEED TO BE REGISTERED.

It is extremely important that information entered into the client registration screen be correct as it establishes the client's identity in the system for the future. **It is recommended that you enter information from the client's Medi-Cal or insurance card, driver's license, or social security card.**

To be billed properly, the patient name must match the insurance information. Medi-Cal cannot be billed if the client's name does not match the billing name.

CLIENT REGISTRATION

```
                    Client Registration


                                    Reporting Unit: ▌     ▌

  Last: ▌          ▌   First: ▌        ▌      Middle: ▌        ▌
  Generation: ▌       Birthdate:  /  /    Sex: ▌    SSN: ▌    ▌ -  -
  CIN: ▌      ▌

  Education: ▌          Other Factors: ▌      Other ID: ▌        ▌
  Disability:          Service Group:         Local Code:
  Language:            Primary RU:            Program Code:
  Ethnicity: ▌ ▌ ▌     Chart Location:        Research Item: ▌      ▌
  Hispanic Origin:     Ref. Staff ID:         Special Population: ▌
  Marital Status:      Care Giver Under 18: ▌   18+: ▌
  Family Size:                                 Enter Address: ▌
  Annual Income: ▌    ▌                         Significant Others: N

  Aliases            Last          First         Middle

                 ▌ ▌         ▌        ▌    ▌      ▌
  V────────────────────────────────────────────────────────V
  Form Ok Y/N: ▌          Confidential Information    USER: ▌      ▌
  Enter a registration provider code.
```

FROM THE MAIN MENU:

1. Select **CLIE**nt or **1** <enter>
2. Select **RE**gistration <enter>
3. Enter data in the following fields：

• **RU:** Enter the Reporting Unit Number for the program where you are registering the client. With decentralized registration, the system automatically assigns a client number and you can enter episodes and services for the client

• **Last Name:** Enter a last name with up to 16 letters. Leave out apostrophes, dashes and blank spaces. For example "O'Connor" should be typed "OCONNOR".

• **First Name:** Enter a first name with up to 12 letters.
• **Middle Name:** Enter the middle name.

• **Client Generation:** Enter a generation title that is part of the client's name, such as Jr., Sr., or the Roman Numerals II, III, *etc*.

- **Birthdate:** Enter the birth date in MM/DD/YYYY format.

- **Sex:** Enter "F" for female, "M" for male, or "U" for unknown.

- **Social Security Number:** Enter a nine-digit Social Security Number. It is best to copy this key information directly from the client's Social Security Card if possible. If the client does not have one, enter all 9's in this field.

- **Education:** Enter the number of the highest grade completed. For example, if the client has completed high school, enter "12". If the highest grade is greater than 20, enter "20". Enter "99" for unknown.

- **Disability:** Type in the number indicating the physical disability. If more than one applies, add codes together and use the sum as the code. (*E.g., if client is deaf=2 and speech impaired=4, the sum will be 6. You need to enter 6 as the physical disability code*).

- **Language:** Enter the client's Primary Language on the 1st field, and the client's Preferred Language on the 2nd field. Primary language identifies the language utilized by the client. Preferred Language identifies the language in which the client would prefer to receive mental health services.

- **Ethnicity** Enter the Ethnicity code. Refer to the Initial Contact Form.

- **Hispanic Origin** Enter "1" if the client is of Hispanic Origin, "2" if the client is Not Hispanic, or "3" for Unknown.

- **Marital Status:** Enter the Marital Status code. : 1-Never Married   2-Married/Live together   3-Widowed 4-Divorced/Dissolved/Annuled 5-Separated   9-Unknown. These codes and other are listed on the Initial Contact Form.

- **Other Factors:** No longer required.

- **Care Giver:** 00 = None   99 = Unknown/Not Reported
01 thru 98 = Identifies the number of children less than 18 years of age that the client cares or dependent adults 18 years of age and above that the client cares for/is responsible for at least 50% of the time.

- **Program Code:** AB2726/AB3632 = 2   Homeless Program = 8

- **Enter Address:** This is not a data field; it is a question. If you enter "Y", the system will jump to the Address Screen. Once you are done with that screen, the system will <enter> you to the Registration Screen.

- **Special Population:** Information is used to determine the number and types of services being provided to specified client groups. A = Assisted Outpatient Treatment Service(s) (AB 1421)
G = Governor's Homeless Initiative (GHI) Service(s) N = No Special Population Service(s) W = Welfare-to-Work Plan Specified Service(s)
- **Aliases:** If the client has ever used aliases, enter them here. As you add information, this section of the screen scrolls upward to allow more information to be entered. You may enter up to six aliases via the Client Registration Screen, and enter more through the Client Maintenance screen if necessary. After you have entered all this data, the cursor moves to the Form OK prompt.
Enter "Y" to save the data you entered

KEEP THE CODE LIST FOR EACH CATEGORY AVAILABLE BY THE TERMINAL.

If the computer does NOT find another client with same information, (i.e., SSN, combined name and DOB) a new number will be assigned appearing at the address insert screen.
If the computer finds another client with the same information, a message will appear at the bottom

of the screen and the registration will be aborted by the computer system. If there are 2 different clients with the same social security number or duplicate medical record number, contact Medical Records at (909) 421-9350 A.S.A.P. so this can be fixed right away. If the error is due to the same name and DOB, contact the F.I. Office's at (909) 421- 9412 to insure the information is correct. If it is, press Num Lock-A and re-enter the registration.

RULES TO FOLLOW

• Do NOT register a new name with a SPACE, HYPHEN, or a DASH unless the client will be billed that way. Enter the client in SIMON the way that Medi-Cal or other Insurance has their name listed.

Double last names:

• Mary Smith-Jones might be listed this way on her driver's license, but Medi-Cal usually has it Mary S. Jones. Register her in SIMON with the spelling Medi-Cal used and put in aliases for SMITH-JONES and SMITH.

Enter:
• Client birth last name, birth first name, birth middle name
• Client generation   Client birthplace   • Client mother's first name
• Period date completed <enter>
• After you have entered all this data, the cursor moves to the Form OK prompt.
Enter "Y" to save the data you entered. At form OK (y/n) enter y <enter>.

Place of Birth

The field is consists of three separate subfields: Birth County, Birth State, and Birth Country. All subfields must be completed. Please refer to the list of valid county, state and country codes.

VALID CALIFORNIA COUNTY CODES:

01 =Alameda	22 =Mariposa	43 =Santa Clara
02 =Alpine	23 =Mendocino	44 =Santa Cruz
03 =Amador	24 =Merced	45 =Shasta
04 =Butte	25 =Modoc	46 =Sierra
05 =Calaveras	26 =Mono	47 =Siskiyou
06 =Colusa	27 =Monterey	48 =Solano
07 =Contra Costa	28 =Napa	49 =Sonoma
08 =Del Norte	29 =Nevada	50 =Stanislaus
09 =El Dorado	30 =Orange	51 =Sutter
10 =Fresno	31 =Placer	52 =Tehama
11 =Glenn	32 =Plumas	53 =Trinity
12 =Humboldt	33 =Riverside	54 =Tulare
13 =Imperial	34 =Sacramento	55 =Tuolumne
14 =Inyo	35 =San Benito	56 =Ventura
15 =Kern	36 =San Bernardino	57 =Yolo
16 =Kings	37 =San Diego	58 =Yuba
17 =Lake	38 =San Francisco	
18 =Lassen	39 =San Joaquin	
19 =Los Angeles	40 =San Luis Obispo	00 =Not California County
20 =Madera	41 =San Mateo	99 =Unknown California
21 =Marin	42 =Santa Barbara County	

VALID STATE CODES:

AL =Alabama	LA =Louisiana	OK =Oklahoma
AK =Alaska	ME =Maine	OR =Oregon
AZ =Arizona	MD =Maryland	PA =Pennsylvania
AR =Arkansas	MA =Massachusetts	RI =Rhode Island
CA =California	MI =Michigan	SC =South Carolina
CO =Colorada	MN =Minnesota	SD =South Dakota
CT =Connecticut	MS =Mississippi	TN =Tennessee
DE =Delaware	MO =Missouri	TX =Texas
DC =District of Columbia		
	MT =Montana	UT =Utah
FL =Florida	NB =Nebraska	VT =Vermont
GA =Georgia	NV =Nevada	VA =Virginia
HI =Hawaii	NH =New Hampshire	WA =Washington
ID =Idaho	NJ =New Jersey	WV =West Virginia
IL =Illinois	NM =New Mexico	WI =Wisconsin
IN =Indiana	NY =New York	WY =Wyoming
IA =Iowa	NC =North Carolina	
KS =Kansas	ND =North Dakota	UN =Unknown State
KY =Kentucky	OH =Ohio	00 =Not US State

VALID COUNTRY CODES:

00 =Country Not Listed	HM =Hearrd/McDonald Isle	SH =St Helena
99 =Unknown Country	HO =Honduras	SL =Sierra Leone
AA =Aruba	HQ =Howland Island	SM =San Marino
AC =Antigua & Barbuda	HR =Croatia	SN =Singapore
AF =Afghanistan	HU =Hungary	SO =Somalia
AG =Algeria	IC =Iceland	SP =Spain
AJ =Azerbaijan	ID =Indonesia	SR =Serbia
AL =Albania	IM =Man, Isle of	ST =St Lucia
AM =Armenia	IN =India	SU =Sudan
AN =Andorra	IO =British Indian Ocean	SV =Svalbard
AO =Angola	IP =Clipperton Island	SW =Sweden
AQ =American Samoa	IR =Iran	SX =South Georgia
AR =Argentina	IS =Israel	SY =Syria
AS =Australia	IT =Italy	TC =United Arab Emirates
AT =Ashmore & Cartier Isl.	IV =Cote D'Ivoire	TD =Trinidad & Tobago
AU =Austria	IZ =Iraq	TE =Tromelin Island
AV =Anguilla	JA =Japan	TH =Thailand
AY =Antartica	JE =Jersey	TI =Tajikistan
BA =Bahrain	JM =Jamaica	TK =Turks & Caicos Isles
BB =Barbados	JN =Jan Mayen	TL =Tokelau
BC =Botswana	JO =Jordan	TN =Tonga
BD =Bermuda	JQ =Johnston Atoll	TO =Togo
BE =Belgium	JU =Juan De Nova Isl.	TP =Sao Tome & Principe
BF =Bahamas, The	KE =Kenya	TS =Tunisia
BG =Bangladesh	KG =Kyrgyzstan	TU =Turkey
BH =Belize	KN =Korea, Democratic RP	TV =Tuvalu
BK =Bosnia & Herzegovina	KQ =Kingman Reef	TW =Taiwan
BL =Bolivia	KR =Kiribati	TX =Turkmenistan
BM =Burma	KS =Korea, Republic Of	TZ =Tanzania
BN =Benin	KT =Christmas Island	UG =Uganda
BO =Belarus	KZ =Kazakhstan	UK =United Kingdom
BP =Soloman Islands	LA =Laos	UP =Ukraine
BQ =Navassa Island	LE =Lebanon	UV =Burkina
BR =Brazil	LG =Latvia	UY =Uruguay
BS =Bassas Da India	LH =Lithuania	UZ =Uzbekistan
BT =Bhutan	LI =Liberia	VC =St Vincent/Grenadines
BU =Bulgaria	LO =Slovakiasi Slovenia	VE =Venezuela
BV =Bouvet Island	LQ =Palmyra Atoll	VI =British Virgin Islands
BX =Brunei	LS =Liechtenstein	VM =Vietnam
BY =Burundi	LT =Lesotho	VQ =Virgin Islands
CA =Canada	LU =Luxembourg	VT =Vatican City
CB =Cambodia	LY =Libya	WA =Namibia
CD =Chad	MA =Madagascar	WE =West Bank
CE =Sri Lanka	MB =Martinique	WF =Wallis & Futuna
CF =Congo	MC =Macau	WI =Western Sahara
CG =Zaire	MD =Moldova	WQ =Wake Island
CH =China	MF =Mayotte	WS =Western Samoa
CI =Chile	MG =Mongolia	WZ =Swaziland
CJ =Cayman Islands	MH =Montserrat	YM =Yemen
CK =Cocos(Keeling)Islands	MI =Malawi	ZA =Zambia
CM =Cameroon	MK =Macedonia	ZI =Zimbabwe
CN =Comoros	ML =Mali	
CO =Colombia	MN =Monaco	
CQ =Northern Mariana Isles	MO =Morocco	

CR =Coral Sea Islands	MP =Mauritius
CS =Costa Rica	MQ =Midway Islands
CT =Central African Rep.	MR =Mauritania
CU =Cuba	MU =Oman
CV =Cape Verde	MV =Maldives
CW =Cook Islands	MW =Montenegro
CY =Cyprus	MX =Mexico
DA =Denmark	MY =Malaysia
DJ =Djibouti	MZ =Mozambique
DO =Dominica	NC =New Caledonia
DQ =Jarvis Island	NE =Niue
DR =Dominican Republic	NF =Norfolk Island
EC =Ecuador	NG =Niger
EG =Egypt	NH =Vanuatu
EI =Ireland	NL =Netherlands
EK =Equatorial Guinea	NO =Norway
EN =Estonia	NP =Nepal
ER =Eritrea	NR =Nauru
ES =El Salvador	NS =Suriname
ET =Ethiopia	NT =Netherlands Antilles
EU =Europa Island	NU =Nicaragua
EZ =Czech Republic	NZ =New Zealand
FG =French Guiana	PA =Paraguay
FI =Finland	PC =Pitcairn Islands
FJ =Fiji	PE =Peru
FK =Falkland Isl.	PF =Paracel Islands
FO =Faroe Islands	PG =Spratly Islands
FP =French Polynesia	PK =Pakistan
FQ =Baker Island	PL =Poland
FR =France	PM =Panama
FS =French Southern	PO =Portugal
GA =Gambia, The	PP =Papua New Guinea
GB =Gabon	PS =Palau
GG =Georgia	PU =Guinea-Bissau
GH =Ghana	QA =Qatar
GI =Gibraltar	RE =Reunion
GJ =Grenada	RM =Marshall Islands
GK =Guernsey	RO =Romania
GL =Greenland	RP =Philippines
GM =Germany	RQ =Puerto Rico
GO =Glorioso Islands	RS =Russia
GP =Guadeloupe	RW =Rwanda
GQ =Guam MT =Malta	SA =Saudi Arabia
GR =Greece	SB =St Pierre & Miquelon
GT =Guatemala	SC =St Kitts & Nevis
GV =Guinea	SE =Seychelles
GY =Guyana	SF =South Africa
GZ =Gaza Strip	SG =Senegal
HA =Haiti	

Client Addresses

Client addresses can be entered and maintained using the Client Address Maintenance Screens. Any authorized user can enter a new address for a client with an open episode. If the client doe not have a valid address used your office address or 700 E. Gilbert St., San Bernardino, CA, 92415

To enter a new address:
1. Choose ADDRESS from the Client Maintenance
2. Press NL-I (I stands for Insert) to display the Client Address Insert Screen.
3. Enter data in the following fields:
Client Number: Enter the number for the client whose address you want to enter. If you are already viewing a list of the client's addresses when you press Num Lock-I, the Client Number is entered automatically.
Reporting Unit: Enter the Reporting Unit Number for the program that has an open episode for the client. The Effective Date of the address you are entering must fall within this episode.
Effective Date: By default, the Effective Date is today's date. Only Supervisors can alter it.
Street Number: Enter a street number with up to five (5) digits.
Street Direction: If the address has one, enter a street direction, such as "N", "NE","E", "SE", "S", "SW", "W", "NW".
Street Name: Enter a street name with up to twenty characters. (Do not enter "Street", "Road", or other street type here.)
Street Type: Enter an abbreviation for the street type, such as "St", "Bl", "Rd.", "Av".
Apartment: Enter up to four characters. Do not enter the symbol "#", and do not enter a period at the end.
City: Enter a city name with up to twenty characters.
State: Enter the two letter abbreviation for the state name.
Zip Code: Enter the first five numbers of the Zip Code, and the cursor moves to the plus-four digits, which you can enter if available.
Phone Number: Enter the telephone number, if available. If you do not want to enter the Area Code, you must type three blank spaces in its place.

```
        Address  Maintenance  Selection



        Client Number:      ▓▓▓▓▓▓▓
        Account Number:


    Effective          Address
    ─────────────────────────────────────────────
       -  -
       -  -
       -  -
       -  -
       -  -
       -  -
    ─────────────────────────────────────────────



  Form Ok Y/N:            Confidential Information         USER:
```

Significant Others

A Significant Other is someone important in the life of the client, such as an employer, relative, guardian, physician, or attorney. These may be emergency contacts or people who can provide transportation or other assistance.

To work with significant other records:
1. Choose CLIENTS from the Main Menu.
2. Choose SIG_OTHER from the Client Maintenance menu to display the Client Significant Others Selection screen

```
Client Significant Others Selection



          Client Number:  [        ]




                              Relation
       Significant Other      to Client      Home Phone     Work Phone   Emer
      ┌─────────────────────────────────────────────────────────────────────┐
      │                                                                     │
      │                                                                     │
      │                                                                     │
      │                                                                     │
      │                                                                     │
      │                                                                     │
      └─────────────────────────────────────────────────────────────────────┘


                    Confidential Information          USER:
```

To enter a new Significant Other:
1. From Client Significant Others Selection screen, press Num Lock-I to display the Significant Other Insert Screen.
2. Enter the number of the client whose Significant Other you are inserting.
3. After the client number is validated, the system lets you enter the other data on the screen.
4. The Relationship to Client field will only hold relationship types specified by your local Operations Staff.
5. There is a scrolled region of the screen with the flags: Emergency Contact, Client's Guardian, Family Member, Do Not Display on Reports. Type "X" next to any flag(s) you want to select.
6. When you are done, press <enter>, and enter "Y" at the Form OK prompt.

To maintain Significant Others:
1. In the Client Significant Others Selection screen, described above, enter a Client Number. The screen displays a list the client's significant others.
2. Type "L" (lookup), or "U" (update), next to the records you want to work with and press Enter.

Examples: Aunt, B&C Operator, Boyfriend, Ex-spouse, Father, Foster Fat, Foster Mo, Foster Mom, Friend, Friends, In-laws, Parole/Off, Payee, Prob. /Off, Sister, Soc. Wkr., Son, etc…

TRANSFER CLIENT NUMBER

FROM DAS TO MHS

You can transfer a client number from DAS to MHS environments by following these procedures, but this special process involves total accuracy. This procedure is used to prevent the production of a different or second client number for one client in the database.

Note: This process can also be used to transfer a client number from MHS to DAS.
First begin with a name search using the MHS Client Locator screen. If you do not locate the client in MHS then you must do a name search in DAS Client Locator screen.
FROM THE MAIN MENU:
      1. Select **DAS**
      2. Select **CLIE**nt or **1** <enter>
      3. Select **LO**cator <enter>
      4. Enter name.

(Using Num Lock-R to refresh the screen between searches) Use the NumLock S keys after locating the client. This procedure will move the client number so you do not have to write it down or remember it. Next, proceed to the Client Maintenance screen and tab over to the maintenance type and place a "L"in the box. Follow the example below:

FROM THE MAIN MENU:
      1. Select **DAS**
      2. Select **CLIE**nt or **1** <enter>
      3. Select **MA**intenance <enter>
      4. Enter: Client number <tab>

Maintenance Type: type "L" (for Look-up)

The client information will appear. Use the print screen option (F2) to print out the client information.
Note: If the social security number is all 9's (999-99-9999) this procedure cannot be used, notify Medical Records immediately.

Third, enter the client information from DAS client maintenance into the MHS client registration screen.

FROM THE MAIN MENU:

      1. Select **MHS**
      2. Select **CLIE**nt or **1** <enter>
      3. Select **RE**gistration <enter>
      4. Enter Reporting Unit <enter>

Enter the client information exactly as it appears on your printout. If you perform this step correctly you will get the same exact client number in MHS that is in DAS. If you receive an ethnicity code error, just omit the code and proceed. After you have transferred the client number you can then update any information that needs to be corrected.

If you receive a different client number you entered the data incorrectly and a duplicate client number will be created. If this happens notify Medical Records immediately.

CLIENT MAINTENANCE / PERIODIC UPDATE

This function is to **UPDATE** or **LOOK-UP** information about the client. You can change the statistical information in SIMON. For the Periodic information you must first update the information in the episode maintenance screen and then enter the information in client maintenance screen and then the new periodic date on the second page.

```
                     Client  Maintenance


   Client Number: ▓▓▓▓▓▓     Maintenance Type: █

  Last: ▓▓▓▓▓▓▓▓▓▓      First: ▓▓▓▓▓▓      Middle: ▓▓▓▓▓▓▓▓
  Generation: ▓▓▓▓   Birthdate:  /  /  ▓▓▓   Sex: █   SSN: 000-00-0000
  CIN: ▓▓▓▓

  Education:        ▓▓   Other Factors:  ▓      Other ID:       ▓▓▓▓
  Disability:       ▓    Service Group:  ▓      Local Code:
  Language:         ▓▓▓  Primary RU:     ▓▓▓    Program Code:
  Ethnicity:   ▓ ▓ ▓ ▓   Chart Location: ▓▓▓▓   Research Item: ▓▓▓▓
  Hispanic Origin:      Ref. Staff ID:   ▓     Special Population: ▓
  Marital Status:       Care Giver Under 18: █  18+: █
  Family Size:       ▓
  Annual Income:    ▓▓▓                         Client UR Needed: █

  Aliases              Last        First      Middle
                  █ ▓▓▓▓▓▓▓▓   ▓▓▓▓▓▓▓▓   █▓▓▓


  Form Ok Y/N: █         Confidential Information        USER: ▓▓▓▓
  Enter a Client Number for maintenance.
```

FROM THE MAIN MENU:

    1. Select **CLIE**nt or **1** <enter>
    2. Select **MA**intenance <enter>
    3. Enter:

Client number <tab>

Maintenance Type: type "U" (for update) or "L" (for Look-up). The client information will appear.
<tab> To the necessary field for change, type over the information to be changed.

To insert Aliases tab down to aliases listing, Num Lock-M, tab again to the aliases listing and type in the information.
When complete <enter>. At form OK (y/n) enter Y <enter>.

This will take you to the second page.

```
              Client  Look-up


      New Client Number: ▮▮▮▮▮            Reporting Unit: ▮▮▮▮  ▮▮▮▮▮▮

   ┌──────────────────────────────────────────────────────────────────┐
   │ Client Birth Name:                                             ▮  │
   │ Last: ▮▮▮▮▮▮       First: ▮▮▮▮▮▮      Middle: ▮▮▮▮▮▮              │
   │ Generation: ▮▮   Birth place: ▮▮▮▮   Mother first name: ▮▮▮    ▮  │
   └──────────────────────────────────────────────────────────────────┘




      Continue: █      Confidential Information      USER: ▮▮▮▮▮▮
```

Enter client's information including birthplace
Type in the Periodic Date Completed <<enter>>
At form OK (y/n) enter Y <<enter>>.

This will take you to the third page.

```
              Client  Lookup


      Client Number:

   ┌──────────────────────────────────────────────────────────────────┐
   │ FI CODE: ▮▮▮▮▮▮▮           FI EXP DATE: ▮▮▮▮▮▮▮                  │
   │                                                                    │
   │                                                                    │
   │                                                                    │
   │                                                                    │
   │                                                                    │
   │                                                                    │
   │                                                                    │
   │                                                                    │
   V──────────────────────────────────────────────────────────────────V

      Form OK Y/N: █      Confidential Information      USER: ▮▮▮▮▮▮
```

The Financial Interviewers Office reserves this page for data entry. DO NOT ENTER ANY DATA ON THIS PAGE. At form OK (y/n) enter Y <Enter>.

Episode Opening

Episode Opening Date:_____ **Referred From** _____ **Legal Status:**_____ **Trauma:**_____

Axis I _____   **Primary/Secondary**   **Add'l Axis I**_____   **Primary/Secondary**

Axis II _____   **Primary/Secondary**   **Add'l Axis II**_____   **Primary/Secondary**

Axis III _____   **Axis III** _____   **Axis III** _____

Axis IV _____   **Axis V**_____

                Past Year:_____ **Substance Abuse/Dependence Issue: Y/N/U   Diagnosis:** _____

Clinician _____ **Physician** _____

Living Situation _____   **Employment Status**_____   **Admission Hour** _____

Legal Status _____   **Legal Consent** _____

Client Addtress:_____

                House Number   **Street**   **City**   **State**   **Zip**

Phone #: _____ **Completed By:** _____ **Date:** _____

Episode Closing

Episode Closing Date:_____ **Referred To:** _____ **Reason for Discharge:**_____

Hour of Discharge: _____ **Legal Status:** _____

▪▪
☐ **Check Box if the remaining Closing Information is the same as the opening information**
▪▪

Episode Opening Date:_____ **Referred From** _____ **Legal Status:**_____ **Trauma:**_____

Axis I _____   **Primary/Secondary**   **Add'l Axis I**_____   **Primary/Secondary**

Axis II _____   **Primary/Secondary**   **Add'l Axis II**_____   **Primary/Secondary**

Axis III _____   **Axis III** _____   **Axis III** _____

Axis IV _____   **Axis V**_____

                Past Year:_____ **Substance Abuse/Dependence Issue: Y/N/U   Diagnosis:** _____

Clinician _____ **Physician** _____

Living Situation _____ **Employment Status**_____ **Reason for Discharge:** _____

Legal Status _____   **Legal Consent** _____

Client Addtress:_____

                House Number   **Street**   **City**   **State**   **Zip**

Phone #: _____ **Completed By:** _____ **Date:** _____

San Bernardino County	**Client Name (Last, First, MI):** _____
Behavioral Health Department	
Client Episode Summary	**Client ID#:** _____
Confidential Patient Information	**Reporting Unit:** _____
See Welfare & Institution Code 5328 2/2004	**Booking:** _____
Rev. 7/07/06 White	**(If Applicable)**

CSI Code Explanation

Trauma: Identifies whether or not the client has experienced trauma. Valid codes are: "Y" yes, "N" no or "U" unknown. Note: Trauma identifies clients that have experienced traumatic events including experiences such as: having witnessed violence; having been a victim of crime or violence; having lived through a natural disaster; having been a combatant or civilian in a war zone; having witnessed or having been a victim of a severe accident; or having been a victim of physical, emotional, or sexual abuse.

Axis I: Enter DSM IV diagnosis code for mental health, which may be the primary focus of attention or treatment.

Primary/Secondary: Indicate whether the Axis I mental health diagnosis is the primary mental health diagnosis or secondary diagnosis. Clinical staff should circle primary or secondary. Clerical staff should enter a "P" or "S" on the SIMON (SIMON) episode screen.

Add'l Axis I Dx: Identifies an additional Axis I mental health diagnosis. Again, primary/secondary can be circled to identify primary or secondary.

Axis II: Enter DSM IV diagnosis code for mental health, which may be the primary focus of attention or treatment for mental health service.

Axis II Primary: Indicates whether the Axis II mental health diagnosis is the primary mental health diagnosis. Valid codes are: "Y" yes, "N" no or "U" unknown.

Add'l Axis II Dx: Identifies an additional Axis II mental health diagnosis. Again, primary/secondary can be circled to identify primary or secondary.

Axis III (General Medical Condition Dx): Identifies up to three Axis III diagnoses that most closely identify the client's general medical condition(s) if any. Refer to "Episode Opening & Closing Codes" document.

Substance Abuse/Dependence: Identifies whether the client has a substance abuse/dependence issue. Valid codes are: "Y" yes, "N" no or "U"

Substance Abuse/Dependence Diagnosis: Enter DSM IV diagnosis code for substance abuse/dependence diagnosis if any.

Clinician / Physician: Please indicate name and 4 digit staff number.

Living Situation: Different codes can be identified at time of opening and then at time of closing. Refer to "Episode Opening & Closing Codes" document.

Employment Status: Different codes can be identified at time of opening and then at time of closing. Refer to "Episode Opening & Closing Codes" document.

Legal Consent / Legal Status: Different codes can be identified at time of opening and then at time of closing. Refer to "Episode Opening & Closing Codes" document.

Refer to: Up to three (3) referral codes can be used per episode. Refer to "Episode Opening & Closing Codes" document.
Reason for Discharge - Refer to "Episode Opening & Closing Codes" document.

EPISODE OPENING AND CLOSING CODES

REFERRAL/RECIPIENT CODES

Episode Opening and Closing "Generic" Referral Codes
Indirect Services "Generic" Recipient Codes

These codes are to be used only when there is no specific Mental Health Reporting Unit, or when there is no specific county agency code.

1	Self	1002	Public Health Department
2	Family	1003	Patton State Hospital
3	Friends	1004	Metropolitan State Hospital
4	Employer	1005	Camarillo State Hospital
5	Other	1006	Napa State Hospital
6	County Resident	1007	Atascadero State Hospital
10	State Hospital (MH)	1008	DMH MH Counselor
11	State Hospital (DD)	1009	Contract 24-Hour Care Provider
12	Other Psychiatric Hospital	1010	San Bernardino County Medical Ctr
13	Psychiatric SNF	1011	Los Angeles Crisis Center
14	Alternative to Hospitalization	1012	Jerry Pettis VA Hospital
15	CRTS Program	1013	Loma Linda University Medical Center
17	Jail	1014	Riverside General Hospital
20	Acute Day Treatment	1015	St. Bernardine Hospital
21	Habilitative Day Tx	1016	San Bernardino Community Hospital
30	Emergency Psychiatric	1017	San Antonio Community Hospital
31	Suicide & Crisis	1018	Other Acute Care Hospital
32	Outpatient Clinic	1019	Private Physician
33	Private Mental Health Practice	1020	AWOL, AMA, or Dropout
37	Case Management	1021	Client Moved Away
38	Homeless Program	1022	Client Died
40	Medical Inpatient	1023	Service Completed
41	Medical Outpatient	1024	Children's Network
42	Convalescent Hospital	1025	Public Guardian
43	Department Social Service	1026	LPS
44	Criminal Justice	1027	Public Guardian's Office
45	Drug Abuse Program	1028	Re-establish Conservatorship
46	Alcohol Abuse Program	1029	Conservatorship
47	School/College	1030	CCP
48	Vocational Rehabilitation Program	1031	Jail Services, West Valley
49	Veterans Administration	1032	Jail Services, Glen Helen
50	Clergy or Religious Organization	1033	Jail Services, Central Detention Center
51	Other Human Service	1034	Gateways Satellite
1000	Law Enforcement	1035	Forensic Services Star
1001	Juvenile Hall		

LEGAL CODES

W60000	Voluntary
W51500	72-Hour Hold (Application for Evaluation)
W55850	72-Hour Hold for Minor
W52500	First 14-Day Hold
W52600	Second 14-Day Hold
W52700	Thirty-Day Extension for Grave Disability
W53000	180-Day Post Certification
W53500	Temporary Conservatorship
W53520	Temporary Conservatorship
W53521	Temporary Conservatorship Extension
W53550	Permanent Conservatorship
W53551	Permanent Conservatorship Extension
W65000	Judicial Commitment DD
W65500	Commitment of Minor DD
W65520	Jurisdiction of Juvenile Court
P10260	Not Guilty by Reason of Insanity
P13680	Incompetent To Stand Trial
P13700	Incompetent To Stand Trial
P13720	Incompetent to Stand Trail
P26840	Transfer Correction Criminal
P99998	Other Involuntary Criminal
W99998	Other Involuntary Civil
U99999	Unknown

LIVING SITUATION CODES

05 Foster family home - children
06 Single Room (hotel, motel, rooming house)
07 Group Quarters (dorm, barracks, migrant camp, long-term shelter)
08 Group home
09 CRTS - long-term or transitional
10 Satellite housing
11 Alternatives to hospitalization, 6 beds or less
12 Alternatives to hospitalization, 7 beds or more
13 House or Apartment
14 House or Apartment w/support
15 House or Apartment w/supervision
16 Chaparral Residential
17 Chaparral Intensive
18 Charlee
19 EYH
20 Small Board & Care home (6 beds or less)
21 Large Board & Care home (7 beds or more)
22 Lives w/adopt parent

23 FFA
24 Adult Res/Social Rehab
31 State Hospital
32 VA Hospital
33 SNF/ICF, for Psychiatric reasons
34 SNF/ICF/Nursing home, for physical health reasons
35 General hospital
36 Mental Health Rehab Center
37 PHF/Inpatient Psych
40 Drug Abuse facility
41 Alcohol Abuse Facility
42 Justice Related
50 Temporary Arrangement
51 Homeless, no identifiable county residence
52 Homeless, in transit
99 Unknown

EMPLOYMENT STATUS CODES

01   Competitive job market, 35 hours or more per week
02   Competitive job market, less than 20 hours per week
03   Competitive job market, 20 to 35 hours per week
04   Full-time homemaking responsibility
05   Rehabilitative work, 35 hours or more per week
06   Rehabilitative work, less than 20 hours per week
07   Rehabilitative work, 20 to 35 hours per week
08   School, full-time
09   Job training, full-time
10   Part-time school/job training
11   Volunteer work
12   Unemployed, actively seeking work
13   Unemployed, not actively seeking work
14   Retired
15   Not in the labor force
16   Unknown
17   Resident/Inmate

LEGAL CONSENT

Legal Consent:
     Clients > 13 years old use 0, A - I,
     Clients <=17 use 0, G – I

0   Unknown
9   N/A
A   Temporary Conservatorship
B   LPS
C   Murphy
D   Probate
E   PC 2974
F   Representative Payee without Conservatorship
G   Juvenile Court Dependant of the Court
H   Juvenile Court Ward Status Offender
I   Juvenile Court Ward Juvenile Offender

REASON FOR DISCHARGE CODES

1   Mutual Agreement/Treatment Goals Reached
2   Mutual Agreement/Treatment Goals Partially Reached
3   Mutual Agreement/Treatment Goals Not Reached
4   Client Withdrew: AWOL, AMA Treatment Partially Completed
5   Client Withdrew: AWOL, AMA No Improvement
6   Client Died
7   Client Moved Out of Service Area
8   Client Discharged/Program Unilateral Decision
9   Client Incarcerated
10   Discharge / Administrative Reasons
11   Other

GENERAL MEDICAL CONDITION SUMMARY CODES

01 = Arterial Sclerotic Disease
02 = Heart Disease
03 = Hypercholesterolemia
04 = Hyperlipidemia
05 = Hypertension
06 = Birth Defects
07 = Cystic Fibrosis
08 = Psoriasis
09 = Digestive Disorders (Reflux, Irritable Bowl Syndrome)
10 = Ulcers
11 = Cirrhosis
12 = Diabetes
13 = Infertility
14 = Hyperthyroid
15 = Obesity
16 = Anemia
17 = Allergies
18 = Hepatitis
19 = Arthritis
20 = Carpal Tunnel Syndrome
21 = Osteoporosis
22 = Cancer
23 = Blind / Visually Impaired
24 = Chronic Pain
25 = Deaf / Hearing Impaired
26 = Epilepsy / Seizures
27 = Migraines
28 = Multiple Sclerosis
29 = Muscular Dystrophy
30 = Parkinson's Disease
31 = Physical Disability
32 = Stroke
33 = Tinnitus
34 = Ear Infections
35 = Asthma
36 = Sexully Transmitted Disease (STD)
37 = Other
99 = Unknown / Not Reported General Medical
00 = No General Medical Condition

San Bernardino County
Behavioral Health Department

CSI PERIODIC DATA
Confidential Patient Information
See Welfare & Institutions Code:5328

Reporting Unit Number: _____

Client Number: _____

Client Name:
Last:_____   First: _____   MI: _____

PLEASE Print Legibly

1: Periodic date completed: __ __ / __ __ / __ __ __ __

2: Education: _____

> Enter in the number indicating the **highest grade** completed. If the highest grade is greater than 20, enter "20", if the highest grade is unknown then enter "99".

3 Employment Status: _____

Employment: (circle one)

1	Full time, 35 hours or more per week	11	Volunteer Worker
3	Part time, less than 35 hours per week	12	Actively looking for work
4	Homemaker	13	Other
5	Full time, 35 hours or more per week	14	Retired
6	Part time, less than 35 hours per week	16	Unknown / Not Reported
8	Student	17	Resident / inmate of institution

4 Axis 5/GAF Rating: _____

Identifies the Global Assessment of Functioning (Axis-V / GAF) rating of the client. Enter '000' if Axis-V / GAF rating cannot be determined.

5:Legal Consent-: _____

Indicate what authority you have to treat minors.

Consent: (circle one)

A - Temporary Conservatorship	F - Representative Payee w/out Con
B - Lanterman-Petris-Short	G - Juvenile Crt, Dependent of Crt
C - Murphy	H - Juvenile Crt, Ward Status Off
D - Probate	I - Juvenile Crt, Wart Juv Off
E - PC 2974	9 -Not Applicable

6:Living Situation: _____

5-Foster family	16-Supported housing	34-SNF/ICF/Nursing Home	52-Homeless, in transit
6-Single room	20-Small Board & Care	35-General hospital	98-Other
7-Group quarters	21-Large Board & Care	36-Mental Health Rehab	99-Unknown
8-Group home	22-Residential Tx Cntr	37-PHF/Inpatient Psych	
9-CRTS long-term/temp	23-Community Tx Facility	40-Drug abuse facility	
10-Satellite housing	24-Adult Res/Social Reh	41-Alcohol abuse facili	
13-House or apartment	31-State Hospital	42-Justice related	
14-House or apt w/supp (adult)	32-VA Hospital	50-Temp. arrangement	
15-House or apt w/super (Adult)	33-SNF/ICF, Psych Reason	51-Homeless, no res.	

7:Care Giver: Under 18: _____   Over 18: _____

> Enter the number of persons the client cares for or is responsible for at least 50% of the time, under the age of 18 and over the age of 18.

Completed by: _____   Date: _____

Input by: _____   Date: _____

CSI Periodic (7/26/06)

Client Episodes

An Episode is a period of treatment for a client at a program. Before you can enter services for a client, there must be an open Episode for the client in the program providing the service.

Opening New Episodes, Mental Health Programs

To open an Episode for a client:

1. Choose EPISODES from the Main Menu.
2. Choose OPEN from the Episode Maintenance Menu to display the Episode Opening screen.

3. To identify the record, fill in the fields at the top of the screen:
-   **Client Number:** Enter a Client Number

-   **RU:** Enter a Reporting Unit number representing a Mental Health program.

4. The system validates the data. It will not let you open an episode unless the Client and RU numbers exist, and it will not let you open two episodes for the same client in the same reporting unit. If these identifying fields are valid, you can enter data in the following fields:

-   **Opening Date:** Enter today's date or an earlier date. The system will not accept a future date. Remember that you cannot enter services that occurred before the episode's opening date.

```
                    Episode  Opening


Client Number: ▒▒▒▒▒▒▒█                                 RU:
 ┌─────────────────────────────────────────────────────────────────┐
 │ Street No.:      Direction:   Name:                Type:    Apt:  │
 │ City:                    State:    Zip Code: 00000+0000 Ph #: (  )   - │
 ├─────────────────────────────────────────────────────────────────┤
 │ Opening Date:   /  /        Referral From:      Legal:       Trauma: │
 │              ┌──── Initial Diagnostic Impression ────┐          │
 │ Axis 1:         Axis 2:         Axis 3:      Axis 4:   Axis 5:    Past: │
 │ Axis 1:         Axis 2:         Axis 3:         Substance Abuse/Dependence │
 │                                 Axis 3:         Issue:    Diagnosis: │
 ├─────────────────────────────────────────────────────────────────┤
 │ Clinician ID:       Living Situation:      Admission Hour: 99  Scheduled: N │
 │ Physician ID:       Employment Status:     Legal Consent:      DNR: N │
 │ Source of Income:   Type of Employment:    Research Item: │
 ├─────────────────────────────────────────────────────────────────┤
 │ Patient Location:       Effective:   /  /                        │
 └─────────────────────────────────────────────────────────────────┘

 Form Ok Y/N:            Confidential Information        USER:

 Enter a client and reporting unit.
```

- **Referral From:** If you have the code for the reporting unit or agency that referred the patient, enter it here. Otherwise, you can enter a one or two-digit generic code numbers.

- **Legal:** Enter a Legal Status code

- **Trauma:** Enter 'Y' - if client has experienced traumatic events, otherwise, enter 'N' for "No" or 'U' for "Unknown".

Next, the cursor moves to the fields in the Diagnostic area. This area has two lines, the first for the main diagnoses and the second for alternative diagnoses.

To enter the main Diagnoses (line 1):

1. Press the Tab key to move through the Axis fields in line one of the Diagnostic area, and enter diagnosis numbers in them.

2. The Tab key will also move the cursor to the Principle/Secondary field next to the Axis 1 and Axis 2 fields. By default, Axis 1 is the primary and Axis 2 is the secondary diagnosis, but you can change this by pressing the Space Bar to clear these fields, and then typing "P" next to the Primary diagnosis and "S" next to the Secondary Diagnosis. Every episode must have one Primary and one Secondary Diagnosis.

The Axis fields hold the following data:

- **Axis 1** and **Axis 2:** Enter five-digit diagnostic codes with a decimal point (period) between the third and fourth digits: for example, 296.44. Some codes have a "V" as the initial digit: for example, V71.09. Ask your system manager for the codes. You must enter data in these fields. (These two fields have "P" and "S" to their right, to indicate which is the primary and which is the secondary diagnosis.)

- **Axis 3:** Enter Axis 3 diagnosis code or summary code. You must enter at least one of these fields. If more than one field is entered, the entered values must be either all diagnoses or all summary codes. Mixing the two codes is not allowed.

- **Axis 4:** Enter a code determined by the local agency. Ask your system manager for the codes. You must enter data in this field.

- **Axis 5** and **Past 5:** Enter assessments of the client's current and past functioning using the Spitzer GAF Scale. Numbers from 000 to 100 are valid. You must enter data in these fields: if unknown, enter "UK".

- **Substance Abuse / Dependence Flag:** Enter 'Y' - if client has a substance abuse/dependence issue, otherwise, enter 'N' for "No" or 'U' for "Unknown".

- **Substance Abuse / Dependece Diagnosis:** Enter a DSM or an ICD diagnosis code. If diagnosis code is not available, enter "000000".

To enter alternative diagnoses (line 2):

1. Press the Tab key to move through the fields in line two of the Diagnostic Area.

2. Fill out these fields like the fields in line one of the Diagnostic Area. These fields can hold the same codes as the Axis 1, Axis 2, and Axis 3 fields of line one, and you indicate the primary and secondary diagnosis in the same way. However, you must

enter different values in these fields than you entered in line 1, since these are alternative diagnoses.

All the fields on line two are optional.

To enter data in the remaining fields:

1. After you Tab through the diagnostic fields, you enter data in the following fields:

- **Clinician ID:** Enter the primary clinician's identification number.

- **Physician ID:** Enter the physician's identification number.

- **Source of Income:** Enter a one-digit code for the client's largest single source of family income.

- **Living Situation:** Enter the code for the client's living situation.

- **Employment Status:** Enter the code for the client's Employment Status.

- **Type of Employment:** Enter the one-digit code for the occupation of the family's primary wage earner.

- **Admission Hour:** Enter hour of admission, using a number from 0-23. If you skip this field, the default 99 (Unknown) is used.

- **Legal Consent:** Indicate what authority you have to treat minors. This field is also used for some adults

- **Research Item:** This field can be defined by your local agency

- **Scheduled:** Enter "Y" or "N", depending on whether this opening was scheduled.

- **Patient Location:** This field used primarily by inpatient hospital or other 24 hour facilities to indicate the room and or bed the client occupies. Its use depends on local policy.

- **Effective:** Enter date the client began occupying bed or room shown in Patient Location field. If the client moves, use Update to enter new bed/room number and effective date of new bed/room number.

- **Address:** For a new client, enter the client's address in the Address fields.

2. At the Form OK prompt, enter "Y" to save the record

```
                    Episode  Opening


JULIA       JOHNSON                                      PSP OPT
Client Number: 978979025                                 RU: 99991

 Street No.: 0     Direction:   Name:                    Type:    Apt:
 City:                      State:    Zip Code: 00000+0000 Ph #: (   )   -

 Opening Date: 06/11/2006   Referral From: 1       Legal: 1        Trauma: Y
 ───────────────── Initial Diagnostic Impression ─────────────────
 Axis 1: 302.2  P Axis 2: V71.09 S Axis 3: 10    Axis 4: A Axis 5:045 Past: 10
 Axis 1:          Axis 2:          Axis 3: 12       Substance Abuse/Dependence
                                   Axis 3:          Issue: Y  Diagnosis: 302.2

 Clinician ID: 55555    Living Situation:   99  Admission Hour: 99  Scheduled: N
 Physician ID:          Employment Status:  1   Legal Consent:  9   DNR: N
 Source of Income:      Type of Employment:     Research Item:

 Patient Location:         Effective:   /  /

Form Ok Y/N: Y           Confidential Information        USER: COHEN_ET
```

Multiple Episodes

Most agencies let a client have an open episode at more than one reporting unit only in certain situations. For example, a client could have concurrent open episodes in two outpatient programs, or one outpatient and one day treatment program, but not two residential programs.

In some cases, if you try to open an episode for a client who is already open in another program, the screen displays a message such as "Client: 504005569 currently open at reporting unit: 36911", and does not allow you to enter data for this client.

The FRC Code

A special field called the FRC code is added to the Episode Opening Screen and the Oneshot Episode Screen for some reporting units. You must enter data in it, if it is present. The FRC Code is used by programs that do not complete Payor Financial Information forms. It is used for mandated external reports.

For example, if the client has no coverage or ability to pay, enter 2. If both the client's family and Insurance will pay, enter 36 (4 + 32).

Code	Meaning
01	Medicaid
02	No Coverage
04	Client or Family
08	Medicare
16	PHP/HMO
32	Insurance and Other Third Party
99	Unknown

Closing Episodes, Mental Health Programs

To close an episode for a client in a reporting unit:

1. Choose EPISODES from the Main Menu.

2. Choose CLOSE from the Episode Maintenance Menu to display the Episode Closing screen. This screen is similar to the Client Episode Opening Screen, with a few exceptions. In addition to Opening Date, it has Closing Date. Instead of Referral From, you can enter Referral To codes. A number of fields are not included, since that data is collected at Episode Opening only.

```
                  Episode  Closing



Client Number: [        ]                              RU:

 Street No.:        Direction:    Name:                    Type:    Apt:
 City:                      State:    Zip Code: 00000+0000 Ph #: (   )   -

 Opened:   -  -       Closing Date:  / /      Discharge Hour:    Legal:
 Last Service:   -   -       Trauma:
                     ── Final Diagnostic Impression ──
 Axis 1:           Axis 2:          Axis 3:        Axis 4:   Axis 5:    Past:
 Axis 1:           Axis 2:          Axis 3:           Substance Abuse/Dependence
                                    Axis 3:           Issue:   Diagnosis:

 Clinician ID:       Living Situation:       Referrals:      /      /
 Physician ID:       Employment Status:      Reason for Discharge:
 DNR: N                                      Research Item:


 Form Ok Y/N:            Confidential Information         USER:

Enter a client and reporting unit.
```

Note: Some 24 Hour programs cannot close an episode unless there is a recorded service for every day of the episode. Ask your Operations Staff for more information about this.

3. Use the fields at the top of the panel to identify the record:

- **Client Number:** Enter the Client Number

- **RU:** Enter the Reporting Unit Number for the program.

4. The system displays an error message if it cannot find an open episode for this client in this reporting unit, or if you are not authorized to close episodes in this reporting unit. If it finds the open episode for the client, it displays the current data as defaults for closing. You use the following fields:

- **Closing Date:** You must enter a closing date, and you cannot enter a future date or a date before the last service. The current date as the default.

- **Last Service Date:** This field is displayed, but you cannot edit it. Usually, it will want make the Closing Date the same as the Last Service Date.

- **Diagnostic, Clinician, Physician, Living Situation and Employment:** Update these fields if necessary, or just press the Tab key to move through them.

- **Referrals:** Enter codes for up to three referral destinations. Use one or two-digit generic codes or the codes for programs or agencies.

- **Reason For Discharge:** Enter a Reason for Discharge code.

- **Research Item:** Make an entry here only if you are authorized. Ask your supervisor for information on this field.

- **Address Fields:** Update these fields if necessary.

4. Enter "Y" at the Form OK prompt to save the data. After validating the data, the system closes the episode.

```
                    Episode Closing


JULIA        JOHNSON                                    PSP OPT
Client Number: 978979025                               RU: 99991

 Street No.: 0     Direction:   Name:                        Type:    Apt:
 City:                      State:    Zip Code: 00000+0000 Ph #: (    )    -

 Opened: 11-Jun-2006  Closing Date: 06/21/2006 Discharge Hour: 99 Legal: 1
 Last Service:    -    -       Trauma: Y
                        ┤ Final Diagnostic Impression ├
 Axis 1: 302.2  P Axis 2: V71.09 S Axis 3: 10      Axis 4: A Axis 5:045 Past:
 Axis 1:          Axis 2:          Axis 3: 12       Substance Abuse/Dependence
                                   Axis 3:          Issue: Y  Diagnosis: 302.2

 Clinician ID: 55555  Living Situation:  99   Referrals: 1     /      /
 Physician ID: 0      Employment Status: 1    Reason for Discharge: 1
 DNR: N                                       Research Item:


 Form Ok Y/N: Y            Confidential Information      USER: COHEN_ET
```

Maintaining Episodes, Mental Health Programs

To maintain Episode records:

1. Choose EPISODES from the Main Menu.
2. Choose MANAGEMENT from the Episode Maintenance Menu to display the Episode Maintenance Selection screen.

```
          Episode Maintenance Selection

     Client Number:
     Reporting Unit:          (Optional)
     Opening Date:    /  /    (Optional)

                    Opening   Closing
     Reporting  Unit   Date      Date    Clinician      Physician




                    Confidential Information      USER: SMITH
Please enter a client number.  A provider number may also be entered.
```

3. Enter search criteria in the fields at the top of the screen:

- **Client Number:** You must enter a Client Number.

- **Reporting Unit:** Optionally, you can enter a Reporting Unit number to display only the client's episodes in that program.

- **Opening Date:** Optionally, you can enter a date to display only episodes that were open at that time. (Enter just a month and year to get a list of episodes with opening dates in that month.)

4. Press <enter>, and the screen lists all Episodes that match the search criteria, with the most recent Episodes first.

5. To select episodes on the list for maintenance, move the cursor through the list (as described in the section on Moving Through Lists in Chapter 1).   Next to the records you want to maintain, enter "L" (lookup), or "U" (update).

```
          Episode  Maintenance  Selection


        Client Number:     153201    PAUL          PASTEL
        Reporting Unit:              (Optional)
        Opening Date:      /  /      (Optional)


                         Opening   Closing
         Reporting Unit    Date      Date      Clinician      Physician

    U HCPC           21861  20-Apr-93            STAFF         Staff
    L DCI-HCPI       22651  20-Apr-93 20-Apr-93 SMITH         Staff
      MOBILE CRISIS  22531  19-Apr-93            CUMINGS       Staff
    D HCPC           21861  18-Mar-93 22-Mar-93 STAFF         Staff
      PSP OPT        22271  18-Mar-93 05-May-93 LAMBERSON     Staff
      DCI-HCPI       22651  18-Mar-93 18-Mar-93 VILLERE       Staff


               Confidential Information        USER: SMITH_D
```

6. Select up to sixteen records. Then press <enter> to display these records for maintenance.

Episode Lookup

If you entered "L", the system displays the Episode Lookup Screen. You can view the data for the Episode but cannot change it.   Press Enter to display the next record selected for maintenance. Type "N" and press Enter to go back to the Client Episode Maintenance Selection Screen.
.

Episode Update

If you entered "U", the system displays the Episode Update Screen. Only Supervisors can change the episode boundaries (*e.g.*, Opening Date). Any authorized user can change the data below these fields.

```
                    Episode  Update

                                      Entered By: COHEN_ET
  JULIA          JOHNSON          PSP OPT    Last Changed: 11-Jun-2006
  Client Number: 978979025        RU: 99991  Last Service:   -   -

 ┌───────────────────────────────────────────────────────────────────┐
 │ Opening: 6 /11/2006   Closing Date:   / /                Trauma: Y │
 ├───────────────────────────────────────────────────────────────────┤
 │ Axis 1: 302.2  P Axis 2: V71.09 S Axis 3: 10    Axis 4: A Axis 5:045 Past: 10 │
 │ Axis 1:          Axis 2:          Axis 3: 12     Substance Abuse/Dependence │
 │                                   Axis 3:        Issue: Y  Diagnosis: 302.2 │
 ├───────────────────────────────────────────────────────────────────┤
 │ Clinician ID: 55555    Living Situation Entry:  99   Referral Source: 1 │
 │ Physician ID: 0        Living Situation Exit:        Admit Hr: 99 Disch Hr: │
 │ Legal Entry:  1        Employment Status Entry: 1    Legal Consent: 9 │
 │ Legal Exit:   1        Employment Status Exit:       Reason For Discharge: │
 │ Source of Income: 0    Referrals:       /     /           Research Item: │
 │ Type of Employ:   0    DNR: N                            Scheduled:     N │
 │ Patient Location:        Effective:   / /  │
 └───────────────────────────────────────────────────────────────────┘

                    Episode Requires UR: Y
      Form OK:           Confidential Information        USER: COHEN_ET
```

Press Tab to move through the fields and edit the data. Press <enter> at any time to move to the Form OK prompt, and enter "Y" to save the changes. The system validates the data: if there are errors, it displays a message and returns the cursor to the field that needs to be corrected.
After you have updated the record, press <enter> to display the next Episode selected for maintenance, or if none are left, to return to the Client Episode Maintenance Selection screen.

Episode Update, Supervisor Authorization

Authorized users can display the screen in Supervisor mode

Episodes Update, Supervisor Authorization

```
                    Episode  Update
                    Supervisor
                                        Entered By:
                            PHOENIX     Last Changed:  4-Aug-19
Client Number:              RU:         Last Service:    -   -

┌─────────────────────────────────────────────────────────────────────┐
│ Opening:   / /      Closing Date:   / /      Re-open Episode: N  Trauma:│
├─────────────────────────────────────────────────────────────────────┤
│ Axis 1:        P Axis 2: 000.00 S Axis 3: V71.09 Axis 4: 0 Axis 5:00  Past: 00│
│ Axis 1: V71.09   Axis 2: V71.09   Axis 3: V71.09 Substance Abuse/Dependence│
│                         Axis 3:          Issue:    Diagnosis:          │
├─────────────────────────────────────────────────────────────────────┤
│ Clinician ID: 0       Living Situation Entry:     Referral Source:     │
│ Physician ID: 0       Living Situation Exit:      Admit Hr:    Disch Hr:│
│ Legal Entry:          Employment Status Entry:    Legal Consent:       │
│ Legal Exit:           Employment Status Exit:     Reason For Discharge:  0│
│ Source of Income: 0   Referrals: 20    /      /          Research Item: │
│ Type of Employ:   0   DNR:                              Scheduled:     N│
│ Patient Location:      Effective:   / /                                │
└─────────────────────────────────────────────────────────────────────┘

     Form OK:            Confidential Information        USER:

Supervisor authorization in effect.
```

To display the screen in Supervisor mode:

1. Display the Episode Update screen, as described above.
2. Press Num Lock-A to display the screen in Supervisor mode.
With this screen, you can change the opening and the closing date of the episode.
If the episode is closed, you can enter "Y" in the Re-open Episode field to open it. Do this if you have closed an episode for a client and then find that the client receives more services after the closing date.

Copying and Transferring Episodes

Episodes can be copied or transferred from one Reporting Unit to another.

To copy or transfer episodes:

1. Display the episode by using either the Look-Up or Update screen, described above.
2. Press Num Lock-F to display a function key map.

```
                    Episode Look-up

                                      Entered By: COHEN_ET
 JULIA          JOHNSON           PSP OPT      Last Changed: 11-Jun-2006
 Client Number: 978979025         RU: 99991    Last Service:   -   -
┌─────────────────────────────────────────────────────────────────────┐
│ Opening: 6 /11/2006   Closing Date:   / /                  Trauma: Y  │
├─────────────────────────────────────────────────────────────────────┤
│ Axis 1: 302.2  P Axis 2: V71.09 S Axis 3: 10    Axis 4: A Axis 5:045 Past: 10│
│ Axis 1:          Axis 2:          Axis 3: 12     Substance Abuse/Dependence  │
│                                   Axis 3:        Issue: Y  Diagnosis: 302.2  │
├─────────────────────────────────────────────────────────────────────┤
│ Clinician ID: 55555   Living Situation Entry:  99   Referral Source: 1      │
│ Physician ID: 0       Living Situation Exit:        Admit Hr: 99 Disch Hr:  │
│ Legal Entry:  1       Employment Status Entry: 1    Legal Consent: 9        │
│ Legal Exit:   1       Employment Status Exit:       Reason For Discharge:   │
│ Source of Income: 0   Referrals:      /    /            Research Item:      │
│ Type of Employ:   0   DNR: N                           Scheduled:     N     │
│ Patient Location:       Effective:   / /                                    │
└─────────────────────────────────────────────────────────────────────┘

     Continue: Y            Confidential Information         USER: COHEN_ET
 ▐FACE▌ ▐    ▌ ▐    ▌ ▐    ▌ ▐    ▌     ▐COPY▌  ▐TRANS▌ ▐    ▌ ▐    ▌
 Task is in the task debugger
```

This map corresponds to function keys F6-F12. For example, you can press F6 to print a Client Face Sheet for this client and press F11 or F12 to copy or transfer this episode:

- **Copying Episodes:** You can copy open and closed episodes. When you press F11, the Episode Opening screen is displayed with the cursor in the Reporting Unit field. Type the number of the program where you want to copy the episode, and press <enter>. Then you may edit data in the other fields. Press <enter> and enter "Y" at the Form OK prompt to create the new episode.

- **Transferring Episodes:** You can transfer only open episodes. When you transfer an episode, you close it at one Reporting Unit and open it in another Reporting Unit. When you press F12, the Episode Closing screen is displayed with the cursor in the Closing Date field. Type in the closing date for this episode, and update other fields if you want to. Then press <enter> and enter "Y" at the Form OK prompt to close the episode. The Episode Opening Screen is displayed with the cursor in the Reporting Unit field. Enter the number of the program where you want to transfer the episode you just closed, and press <enter>. All of the data from the original episode is displayed in the Episode Opening Screen, and you may edit it. You may want to update the Referred From field. Press <enter> and enter "Y" at the Form OK prompt to

create the new episode.

One Shot Opening and Closing, Mental Health Programs

The One Shot Screen is designed for Crisis programs. It lets you open and close an episode and record two services using a single screen. This screen is like the Episode Opening and Episode Closing screens: it has both an entry and exit date and a referral source and a referral destination. In addition, it has an area for entering up to two service procedures.

To do one shot opening and closing:

1. Choose EPISODES from the Main Menu.

2. Choose ONESHOT from the Episode Maintenance Menu to display the One Shot Opening and Closing Screen

```
      One  Shot  Opening  and  Closing



Client Number: [        ]                              RU:

 Street No.:       Direction:    Name:              Type:    Apt:
 City:                    State:    Zip Code: 00000+0000 Ph #: (   )   -
                                                          ┌── Legal ──
 Opening:   / /      Ref. From:         Ref. To:        /
                  ──┤Initial Diagnostic Impression├──
 Axis 1:        Axis 2:        Axis 3:        Axis 4:   Axis 5:    Past:
 Axis 1:        Axis 2:        Axis 3:

 Clinician ID:        Living Situation:        Admit Hr: 99 Disch Hr: 99
 Physician ID:        Employment Status:       Legal Consent:
 Source of Income:    Type of Employment:      Research Item:

     Procedure    Time (HH:MM)    Location    Clinician ID    Co-Staff
                      :              1
V─────────────────────────────────────────────────────────────────V
 Form Ok Y/N:            Confidential Information         USER:

Enter a client and reporting unit.
```

3. Most of the fields in this screen are the same as the fields described in the sections in this chapter on Opening Episodes and Closing Episodes.

4. Enter services on two lines at the bottom of the screen, it is similar to the Single Service Entry. They include the following fields:

- **Procedure:** Enter a three-digit procedure code.

- **Time (HH:MM):** Enter the number of hours for the service. Enter hours (up

to 23) and minutes (up to 59) separately. Some services have fixed time limits set by local policy, and you cannot enter a longer time.

- **Location:** Enter the code for the location of the service.

- **Clinician ID:** Enter the staff number for the Primary Therapist, who actually performed the service. The message "Re-enter primary therapist...Illegal procedure for staff", means that the primary therapist is not authorized to provide the selected procedure. For example, if a physician-only procedure is used, a physician's staff number must be entered as the primary therapist.

- **Co-Staff ID:** Enter the staff number for the Co-Therapist for the procedure, if there is one.

5. Enter another service in the second line, if you want. When the form is completed press <enter> to move the cursor to the Form OK prompt, and enter "Y" to save the entry.

VERIFICATION OF ELIGIBILITY AND POE ENTRY

This function is used to verify current status of Medi-Cal eligibility for new and continuing clients. ***This must be done on every client who is Medi-Cal eligible and validated every month for services to be billed***.
FROM THE MAIN MENU:

(1) MHS (7)Select **FI**nancial <Enter> (2) Select **EL**igibility <Enter> (1) Select **ME**dicaid <Enter>

```
         Eligibility Maintenance Selection




          Client Number:      ▓▓▓▓▓▓
          Eligibility Number:
          Eligibility Range:      /    -   /



 Eligibility #   Period      Method      Status      Entry Date Entered By




              Confidential Information          USER:
```

4. Enter: chart number <Enter>
Evaluate current status of Medi-Cal for this client.
If Medi-Cal is not already entered, (e.g., system 27) enter by following the next step, if already
entered for the desired month stop at this point.

TO INSERT ELIGIBILITY:

```
                    E l i g i b i l i t y   I n s e r t

  Client Number:              RU:            Eligibility Number:
  ┌─────────────────────────────────────────────────────────────────────┐
  │  Name:                            Birthdate:    -   -      Sex:      │
  │  Social Security Number: 000-00-0000                                 │
  │                                   Sensitive:     CSI M/C:            │
  │  Eligibility Period:    /      Special Reason Code:   EVC Number:    │
  │  Card Issue Date:    /  /       Confirm Now: Y        Cnty Code:   Aid: │
  │                                                                     │
  │  Street No.:      Direction:    Name:                    Type:   Apt: │
  │  City:                    State:    Zip Code: 00000+0000 Ph #: (   )  - │
  └─────────────────────────────────────────────────────────────────────┘




  Form OK Y/N:            Confidential Information        USER:
  �  Swipe  ▆▆▆▆ ▆▆▆▆ ▆▆▆▆ ▆▆▆▆    ▆▆▆▆ ▆▆▆▆ ▆▆▆▆  Function
  Enter a Client Number and/or an Eligibility Number.
```

5. NumLock-I
6. Enter: client's chart number <tab>
Reporting unit <Enter>
Eligibility number, which is the SSN from the BIC card <tab>
Card Issue Date <Enter>
Verify client's name, date of birth, sex and social security number. Current month is the default for
eligibility month (you can change to any past month you need). If information is correct <Enter>.
If the entry is for 3 or more prior months, you need to enter a SPECIAL REASON CODE
At form OK (y/n) enter Y <Enter>.

READ MESSAGE FROM EDS.
This will tell if the client is eligible for the month you listed for verification.

SHARE OF COST:
If the message says **SHARE OF COST** and there is a dollar amount listed DO NOT CONTINUE and
call the Business Office at 387-7602.

OUT OF COUNTY:
If the message indicates the clients are not San Bernardino County Medi-Cal recipients (County
Code 36) DO NOT CONTINUE and call the Access Unit at (909) 381-2420.
If they are eligible <Enter>. At form OK (y/n) enter Y <Enter>.

INSURANCE COMPANY INFORMATION
(FOR CONTRACT AGENCIES ONLY)

```
Insurance  Policy  Maintenance  Selection


        Client Number:      ▓▓▓▓▓▓▓▓█
        Policy Number:
        Company ID:
        Maintenance Type:


  ID    Insurance Company Name   Policy Number   Entered By  Policy Status




                    Confidential Information          USER:
```

This function is to enter Insurance information for the client. Always check to see if it is already entered.

FROM THE MAIN MENU:
1. Select **FI**nancial <return>
2. Select **EI**igibility <return>
3. Select **PO**licy <return>

Entering a New Insurance Policy

To enter a new insurance policy:

1. Choose **POLICY** from the Eligibility Maintenance menu to display the Insurance Policy Maintenance Selection screen, shown above.

2. Enter Client Number, Company ID (optional), and "I" as Maintenance Type, and press Enter, or simply press **Num Lock-I**, to display the Insurance Policy Insert screen.

3. To identify the record, fill out the fields at the top of the screen:

   • **Client Number:** Enter the Client Number.
   • **Company ID:** If you know it, enter the Insurance Company ID number Then Press Enter. The system displays the client name and insurance company name to the right of these numbers.
   • **Company Name:** If you don't know the insurance Company ID, press Tab to bypass Company ID, and enter the Company Name or a partial name.

The Insurance Company Selection screen displays an alphabetical list of insurance companies beginning with the name of the company you typed (if it is included in the Insurance Company Master Relation). Move through the list of companies, type "X" next to one, and press Enter. The system displays the Insurance Policy Insert screen with name and ID of the insurance company you selected in the top box of the screen.

Note: If you do not find the insurance company you are looking for, ask the Business Office to register the new company.

4. After entering the Client number and Insurance Company ID, fill out the rest of the fields in the Insurance Policy Insert screen. Data is required in the Effective Date, Insured Sex, and Relationship to Insured fields:

- **Group Number:** Client's insurance group number.

- **Policy Number:** Client's insurance policy number.

- **Effective Date:** Date the client's insurance policy is effective. If you do not know, use the first service date that the new system began producing claims. Do not update an effective date to make it prior to the first service date.

- **Expiration Date:** Date the client's insurance policy expires. Do not enter a date in this space unless you are sure that the policy is no longer valid.

- **Insured Name:** Name of the insured person.

- **Insured SSN:** Social Security Number of the insured person.

- **Insured Sex:** Sex of the insured person.

- **Relationship To Insured:** Relationship of the client to insured person from the following choices: Self, Spouse, Child, Other.

- **Employment Related:** X indicates that the client's illness is related to his or her employment, so that this is a Worker's Compensation case. All users authorized to update policies may set or release this flag.

- **Assignment of Benefits:** X indicates that the insured has signed a statement assigning insurance benefits to your agency. Only users with Policy Flags authorization may set or release this flag.

- **Release of Information:** X indicates that the client has signed a statement agreeing to the release of medical information necessary to claim insurance benefits. Only users with Policy Flags authorization may set or release this flag.

- **Information Complete:** X indicates that the insurance policy is currently complete and ready for billing. Only users with Policy Flags authorization may set or release this flag.

5. When you are done, enter "Y" at the Form OK prompt to save the data. If the Relationship to Insured is Self, the system validates the Insured SSN that you entered against the client's Social Security Number. For Medicare the Relationship to Insured is always Self, so the cursor bypasses the box with Insured Name, SSN, etc.

(For the message NO ACCOUNT NUMBER, please call the FI Office)
For Medicare enter codes from the list below: *These are three separate entries.*

9994 (part B) –Aetna

9997 (part A) – Blue Cross

9999 (part B) –National Heritage

This procedure is also used for private or supplemental insurance companies. You must input this in order to bill Medicare for the client.

```
            Insurance  Policy  Insert




 Client Number:  ▓▓▓▓▓▓0█  Client Name:
 Company ID: 0             Company Name:

 Group Number:                  Effective Date:    /  /
 Policy Number:                 Expiration Date:   /  /

 Insured Name:                  Insured Sex:
 Insured SSN:  000-00-0000      Relationship to Insured:

    Employment Related          Assignment Of Benefits
    Release Of Information      Information Complete
V───────────────────────────────────────────────────V



 Form OK Y/N:           Confidential Information        USER:
```

Direct Services

This section covers the different ways to record services provided by programs directly to clients. All of the screens are on the Service Maintenance Menu. Before services can be recorded, the client must be registered and there must be an Episode open for the client in the program providing the service on the date being recorded.

Entering New Direct Services

SIMON gives you several ways of entering services:
- Single Service Entry for all programs

- Daily Service Entry for day programs and 24-hour programs

- Weekly Service Entry for day programs and 24-hour programs

- Multiple Service Entry to enter the same information for a number of services

Single Service entry is most common, and the other methods can sometimes save you time in data entry.

Single Service Entry

Most programs enter services daily using single service entry.

To do single service entry:

1. Choose SERVICES from the Main Menu.

2. Choose SINGLE from the Service Maintenance Menu to display the Single Service Entry Screen.

```
          Single  Service  Entry



Client Number:              Service Date: 9 /20/2006      RU: ▓▓▓▓

  ┌─────────────────────────────────────────────────────────────┐
  │  Procedure:                                                   │
  │                                                               │
  │  Staff:              Staff Duration:      :    Number in Group: 01 │
  │                                                               │
  │  Co-Staff:                                     Location:      │
  │                                                               │
  │  Billing Code:              Modifier_1:        Modifier_2:    │
  │                                                               │
  │  Evidence-Based Practices/Service Strategies:                │
  └─────────────────────────────────────────────────────────────┘


Form Ok Y/N:              Confidential Information        USER:

Enter a reporting unit.
```

3. Enter data in the following fields:

- **RU:** Enter the reporting unit number for your program and press Enter. The system validates the number and displays the program's name.

- **Client Number:** Enter the Client Number. When all the data has been entered, the system will display the name of the client. At that time, review the client name to be sure you are entering services for the correct client.

- **Date:** Enter a date in the format MM/DD/YY. You cannot enter a future date. You must enter a date when the client's episode is open and the program operates.

- **Procedure:** Enter a three-digit procedure code. It must be a valid procedure for the program.

- **Staff:** Enter a staff identification number. The staff number will be validated for authorization to perform the services you are entering.

- **Co-Staff:** If there was co-staff, enter the staff identification number. You may only enter one co-staff in this system.

- **Staff Duration:** Enter the number of hours and minutes this staff person spent in this service. Enter up to twenty-three hours and up to fifty-nine minutes in the two portions of this field. There is a fixed minimum and

maximum time for some services.

- **Co-Staff Duration:** If there was co-staff, enter the time they spent on the service, in the same way as Staff Duration.

- **Number in Group:** Enter a number from 1 to 99 indicating how many *clients* were involved in the service. The default is 01, for an individual service. If you are recording group services, enter the number of clients in the group. (For example, if Staff Person A and B have a group with 10 members that met today for 1 hour with all members present, enter 10 here. SIMON will record a service for each client number, with the staff numbers of A and B, the procedure code for a group, a group count of 10, and the time each staff person spent in the service. Each client will be billed correctly for the group service, and each staff person will be credited correctly for the time spent in the service.)

- **Location:** Enter a location code from 0 to 21.

- **Billing Code:** Enter a billing code.

- **Modifier 1:** Enter modifier 1.

- **Modifier 2:** Enter modifier 2.

- **Evidence Based Practice / Service strategy:** Enter EBP / SS codes. These fields require leading zeroes.

4. When you are done, enter "Y" at the Form OK prompt. The system validates the data and displays the client's name. If there are incorrect values in any field, it will display an error message and return the cursor to that field.

5. Once the data is correct, the system will ask for confirmation before saving it. Enter "Y" at the Confirm prompt to save the entry.

Special Authorizations for the Single Service Entry Screens

Authorized personnel can use these special features of the Single Service Entry Screen.

- **Late Entry:** Press Num Lock-A once to invoke Late Entry authorization. For example, if data entry for April is closed on May 5, Late Entry authorization lets you enter services after that time.

- **Supervisor:** Press Num Lock-A twice to invoke Supervisor authorization, which lets you override system validations in the Staff, Co-Staff, Group Count, Staff Duration, Co-Staff Duration and Location fields, but not episode boundaries. This is useful for recording unusual services.

- **Supervisor and Late Entry:** Press Num Lock-A three times to invoke both Supervisor and Late Entry authorization.

Using the Single Service Entry Screen for Day Treatment

Day Treatment services are normally entered using the Weekly or Daily Entry Screen, but sometimes you should use the Single Service Entry screen.
In SIMON, Day Treatment days or services are not associated with a particular

staff member, and your system will not let you enter a staff person, but will let you enter a "0" for Staff Number. Some Day Treatment programs can bill Medicare for incident-to services, and sometimes they are required to enter some outpatient-type services. These can be entered using the Single Service Entry Screen.

Using the Single Service Entry Screen for Inpatient and other 24 Hour Programs

Inpatient services are normally entered using the Daily Entry Screen, but sometimes you should use the Single Service Entry screen.
In SIMON, inpatient days or services are not associated with a particular staff member, and are assumed to be twenty-four hours in length. In most cases, your system will not let you enter a staff person, but will let you enter "0" for Staff Number. For duration, the system may make you enter 24 hours. You can enter staff numbers and other durations using the Single Service Entry Screen.

Daily Service Entry

You can enter services for all the clients in Inpatient and Residential programs using a single screen.

To do daily service entry:

1. Choose SERVICES from the Main Menu.
2. Choose DAILY from the Service Maintenance Menu to display the Daily Service Entry screen.

3. Fill in the fields at the top of the screen:
- **Service Date:** The default is the current date, but you can also use a past date if there are services still to be entered for that day.

Note: It is best to use this screen is to enter services every day, but there may be times when you put off data entry and then enter several days at a time. ***When you do this, you must enter services chronologically.*** For example, if you need to enter data for Tuesday, March 1, Wednesday, March 2, and Thursday, March 3, then you must enter services for Tuesday first, then for Wednesday, then for Thursday. If you accidentally enter services for March 3, you cannot use this screen for March 1 and 2; you must use the Single Service Entry Screen.

- **RU:** Enter a Reporting Unit Number. If it can enter services using this Screen, the name of the program is displayed above the number.

When you press Enter, the system lists all clients open on this date in this program, twenty-five clients at a time, in alphabetical order. If there are more than twenty-five clients, it displays the message: "Enter services for 25 clients. More clients may exist". After you enter the first twenty-five services, the cursor returns to the date field: press Enter to accept the date and reporting unit for a second time (or more) and display the next 25 clients. Depending on local policy, the program may display the screen with or without a column to enter time. Many residential programs use the screen without a column to enter time.

Note: Some Programs use the Weekly Service Entry Screen (covered below) instead of the Daily Service Entry Screen.

Daily Service Entry without Time

If local policy for this Reporting Unit is not to enter time, the screen is displayed as shown below.

```
                 Daily  Service  Entry


                                          GV INPATIENT
            Service Date: 6 /7 /2006      RU: 99999

   Client Number Client Name            Opening Date Procedure

      1000047   BANNON, LONNIE          05-May-2000  111
      1000052   BERRY, LILLY            08-Jan-1992  111
      1000034   CARPENTER, PATSY        27-May-1996  111
    111111156   FELINE, MAXWELL         02-Jan-1996  111
      1000020   GLASS, BLABBER          01-Sep-1992  111
      1000010   HENDERSON, EUGENE       15-Jan-1991  111
      1000010   HENDERSON, EUGENE       10-Jan-1992  111
      1000101   HENDERSON, JASON        18-Jan-1991  111
      1000032   HERMAN, BABY            06-May-2000  111
      1000029   HORTON, FLAP            17-Apr-1989  111

   Location:      Evidence-Based Practices/Service Strategies:


   Form Ok Y/N:          Confidential Information       User: COHEN_ET
```

To do daily service entry without time:

1. The Client Number, Name, and Opening Date is listed for each client. For each client, you must enter:

- **Procedure Code:** Enter one of the twenty-four hour type procedures codes authorized by your local agency. A default procedure code is displayed if specified by local policy. The user can accept or change this default, or can enter "000" to skip this client; later, you can use the Single Service Entry Screen to record services for clients you skipped by entering "000".

- **Location:** Enter a location code from 0 to 21.

- **Evidence Based Practice / Service strategy:** Enter EBP / SS codes. These fields require leading zeroes.

2. After you have entered the last procedure code, enter "Y" at the Form OK prompt to save your entries.

If there are clients who have a Pending registration, they are noted, but you cannot enter services until the registration has been updated. For more information on Pending Registration, see the section on Client Registration in Chapter 2.
If there are clients whose services have already been entered for the Service Date (for example, through the Single Entry Screen), they are not listed on the screen. This screen does not allow duplicate services.
If you have skipped over clients during your data entry, you can redisplay them by pressing Num Lock-E key to leave the screen. Then use the menu to display the screen, re-enter the date and reporting unit number, and the skipped clients are included in the list.

Daily Service Entry with Time

If local policy for this Reporting Unit is to enter time, the screen is displayed as shown in.

To do daily service entry with time:

1. The Client Number, Name, and Opening Date is listed for each client, and you must enter:

- **Procedure Code:** The screen displays the default procedure code for your program; no other entry is valid in this field. If your program can give clients two different kinds of service in one day—for example, a program that has an rehabilitative day care service and a vocational rehabilitative service—you can enter only one service for each client. You must use the Single Service Entry Screen to enter the second service.

- **Duration:** Enter the number of hours and number of minutes the client attended the program.

- **OK:** If the client was present, type "W" in this field to write the service. If the client was not present, or you wish to skip over the patient for now, type "S".

2. After you have entered the last procedure code, enter "Y" at the Form OK prompt to save your entries.

```
                Daily Service Entry


                                          PSP DT
          Service Date: 6 /7 /2006        RU: 99992

 Client Number Client Name           Opening Date Procedure Duration OK

   100000033   ARNON, ETTIE          03-Nov-1998   295        :
    1000053    BERRY, EGG            08-Jan-1998   295        :
    1000054    BERRY, FRANNY         01-Dec-1997   295        :
   111111184   BUDDHA, SIDDHARTHA    06-Feb-1996   295        :
    1000132    DEE, SANDRA           01-Jun-1993   295        :
   111111142   DINOSAUR, BARNEY      07-Sep-1994   295        :
   111111198   DORIGHT, DUDLEY       22-Aug-1996   295        :
    1000033    DOYLE, SHORTY         15-Mar-1993   295        :
   111111199   FELINE, KELSO         22-Aug-1996   295        :
   111111156   FELINE, MAXWELL       12-Jan-1996   295        :

   Location:      Evidence-Based Practices/Service Strategies:


 Form Ok Y/N:            Confidential Information        User: COHEN_ET
```

4. Enter the Client Number, Service Date, Master Service Procedure Code (in the Procedure field), and Staff Duration (hours: minutes).

Note: If the master service is *not* a day treatment service, you may also be required to enter staff identification number, co-staff number, co-staff duration, and number in group.

5. Enter "Y" at the Form OK prompt. The cursor moves to the framed box in the lower half of the screen.

6. Enter the Component Service Procedure Code, Staff Number, Duration and Location for each component rendered on the service date. The procedure code is required, and the other data is optional. Up to ten component services may be entered for one master service.

7. Enter "Y" at the Form OK prompt.

8. Enter "Y" at the Confirm prompt .

If the master day treatment service has already been entered through another screen, you only need to enter the associated component services.

Weekly Service Entry

Use this screen to enter one week of services at a time for all of the clients in your program. It is used by programs that have one primary procedure code and only one possible unit of time for the service. Residential Programs and certain types of Day Treatment programs are authorized to enter data on a weekly basis rather than a daily basis. If an episode is open in a Residential or Day Treatment program, the client's name and number are automatically listed in the Weekly Service Entry Screen, after Report PSP 125 is run for the week.

Note: Programs that use the Weekly Service Entry Screen *must* use the Reports menu to produce Report PSP125 *each week* before data can be entered. This report creates the data displayed in the Weekly Log Screen, and also produces a paper log with the same data, which can be used for data entry. For more information, see the Reports Manual.

To do weekly service entry:

1. Choose SERVICES from the Main Menu.
2. Choose WEEKLY from the Service Maintenance Menu to display the Weekly Service Entry Screen.

3. Enter search criteria in the fields at the top of the screen:
- **Start Date:** Enter the first day of the week in the format MM/DD/YY. Your Operations Staff defines start date options in a Systems Option File. The Start Date must be a Sunday or a Monday. Data entry can be done on the last work day of the week or after the week is past.

- **RU:** Enter the Reporting Unit Number for your program.

```
                Weekly  Service  Entry



   Mon Start Date: 2 /11/2002            RU: 7777MH     OPT MHS

  ┌────────────────────────────────────────────────────────────────┐
  │ Client                                   Procedure             │
  │ Number     Client Name         Mon Tue Wed Thu Fri Sat Sun   OK │
  └────────────────────────────────────────────────────────────────┘
   ┌─────────────────────────────────────────────────────────────┐
   │ 950661424  ANAYA, LORINA       0█  0   0   0   0   0   0      │
   │ 950661904  BADERY, SAYEDA      0   0   0   0   0   0   0      │
   │ 111111140  BADGUY, JAFAR       0   0   0   0   0   0   0      │
   │  1000197   BEROL, PHENO        0   0   0   0   0   0   0      │
   │  1000053   BERRY, EGG          0   0   0   0   0   0   0      │
   │  1000056   BERRY, FRANK        0   0   0   0   0   0   0      │
   │  1000035   CARPENTER, JIM      0   0   0   0   0   0   0      │
   │  1000107   DOWAGER, MAGGIE     0   0   0   0   0   0   0      │
   │  1000057   FORNES, KEVIN       0   0   0   0   0   0   0      │
   │    3323    GAFFNEY, MIKE       0   0   0   0   0   0   0      │
   └─────────────────────────────────────────────────────────────┘

   Location:      Evidence-Based Practices/Service Strategies:

 Form Ok Y/N:            Confidential Information         USER: COHEN_ET
```

4. If a valid Start Date and Reporting Unit are entered, the Weekly Service Entry Screen lists all clients open in that program for that week in alphabetical order, ten at a time. For each record in the list, enter data in the following fields:

- **Procedure Code:** This field displays the default procedure code for the reporting unit. In most cases this is the only procedure code allowed, except for "000" to indicate that no service was given. There are a few programs that also have other Procedure Codes. You may accept one day's procedure code by pressing Tab, or accept a week's procedure codes by pressing Return to move to the end of the line. (When the services records are recorded, they use the default time for the procedure code entered.)

- **Location:** Enter a location code from 0 to 21.

- **Evidence Based Practice / Service strategy:** Enter EBP / SS codes. These fields require leading zeroes.

- **OK:** This field lets you confirm that the information for this client is correct. Enter "W" to Write the services, "S" to Skip the line, or "D" to Drop the client from this Entry Screen. (If you enter "S", all of the services for that client will be skipped. To write some services for the client but not all, enter "000" for the day the client is to be skipped, and enter "W" in the "OK" field.)

5. Enter "Y" at the Form OK prompt to save the data. The system validates the data, and if there are any errors, it returns the cursor to the field that must be corrected and displays an error message.

6. If there are more clients in the program, press Enter to display the next 10 clients.

The screen lets you record services only for the days the client was open in the program. If a client is opened in the program on Wednesday, the screen will not allow you to enter services for the client for Sunday, Monday, or Tuesday. If a client's registration status is pending, this is noted on the screen and you cannot enter services for that client until the registration has been approved. See the Client Maintenance section in Chapter 2 of this User Manual for information on pending registrations.

```
                  Weekly  Service  Entry


    Mon Start Date: 2 /11/2002              RU: 7777MH    OPT MHS

   Client                                        Procedure
   Number    Client Name             Mon Tue Wed Thu Fri Sat Sun    OK

   950661424  ANAYA, LORINA          341 341 341 341 341 341 341     W
   950661904  BADERY, SAYEDA         342 342 342 342 342 350 350     W
   111111140  BADGUY, JAFAR          350 342 342 341 350 350 350     W
     1000197  BEROL, PHENO            0   0   0   0   0   0   0       S
     1000053  BERRY, EGG              0   0   0   0   0   0   0       S
     1000056  BERRY, FRANK            0   0   0   0   0   0   0       S
     1000035  CARPENTER, JIM          0   0   0   0   0   0   0       S
     1000107  DOWAGER, MAGGIE         0   0   0   0   0   0   0       S
     1000057  FORNES, KEVIN           0   0   0   0   0   0   0       S
        3323  GAFFNEY, MIKE           0   0   0   0   0   0   0       S

    Location: 01    Evidence-Based Practices/Service Strategies: 10 50 61

  Form Ok Y/N:              Confidential Information          USER: COHEN_ET
```

If you have used "S" to skip all of the services for one or more clients, you can still use the eekly Service Entry Screen to record those services by leaving the screen and then displaying it again to begin data entry. The clients you originally skipped are listed on the screen. If you have skipped some services for clients, but not all, those clients will not appear again on the Weekly Service Entry screen for that week. To enter services for them, use the Single Service Entry Screen, described earlier in this chapter.

If you are unsure which services have been recorded and which have not, press Num Lock-S to leave the screen saving the current Reporting Unit Number. Choose SERVICES from the Main Menu, and then choose MANAGEMENT from the Service Maintenance Menu. When the screen prompts you, enter a Client Number and press Enter, to display services for that client in the program. Then return to the Weekly Service Entry Screen to continue service entry.

Multiple Service Entry

The Multiple Service Entry Screen makes it easy to enter repetitive data—for example, to enter a number of services for one client or one staff person, or to enter all of one type of service for a day. It lets you create user-defined defaults that enter the repetitive data automatically.

To do multiple service entry:

1. Choose SERVICES from the Main Menu.

2. Choose MULTIPLE from the Service Maintenance Menu to display the Multiple Service Entry screen. This screen resembles the Single Service Entry screen.

```
Multiple Service Entry

                             RU:



                        Service              Co
     Client              Date     Proc Staff Dur  Staff      Group Loc
  ─────────────────────────── Defaults ──────────────────────────────
  |                        /  /                 :                     |
  ───────────────────────────────────────────────────────────────────
  |                        /  /                 :                     |
  |                        /  /                 :                     |
  |                        /  /                 :                     |
  |                        /  /                 :                     |
  |                        /  /                 :                     |
  |                        /  /                 :                     |
  |                        /  /                 :                     |
  V───────────────────────────────────────────────────────────────V
     Evidence-Based Practices/Service Strategies:

  Form OK Y/N:            Confidential Information       User:

Enter a reporting unit.
```

3. To identify the program you are doing data entry for, enter:

- **Reporting Unit:** Enter the Reporting Unit Number for the program, and the screen displays its name. (To enter services for a different program during the same session, press Num Lock-P to move the cursor back the RU field, or press Num Lock-R to restart the screen.)

4. The cursor moves to the Defaults box. Data you enter here will be repeated for every service you enter in the list below, until you enter new defaults. You can enter default data for one or more of the following fields:

- **Client Number:** Enter a client number.

```
                 Multiple  Service  Entry

                                    RU: 36911  MESA


                         Service              Co
        Client           Date    Proc Staff  Dur  Staff  Dur Group Loc
        ┌───────────────────────── Defaults ─────────────────────────┐
        │               1 /20/5000          :           :      1   1 │
        ├─────────────────────────────────────────────────────────────┤
        │                       / /         :           :            │
        │                       / /         :           :            │
        │                       / /         :           :            │
        │                       / /         :           :            │
        │                       / /         :           :            │
        │                       / /         :           :            │
        │                       / /         :           :            │
        └─────────────────────────────────────────────────────────────┘
   Evidence-Based Practices/Service Strategies:

   Form OK Y/N:              Confidential Information       User:
```

- **Service Date:** Enter a date in the format MM/DD/YY.

- **Procedure:** Enter a three-digit procedure code. The field accepts only direct service procedure codes that are valid for your program.

- **Staff:** Enter a staff identification number. It will be validated for authorization to perform the services you enter.

- **Duration:** Enter the number of hours (up to 23) and minutes (up to 59) the staff person spent in this service. Counties set fixed time ranges for some services.

- **Co-Staff:** Enter the Co-staff identification number, if there is one. It will also be validated for authorization to perform the services you enter. (Your screen may not include this column.)

- **Number in Group:** Enter a number from 1 to 99 indicating how many *clients* were involved in the service. The default is "01" for an individual session.

- **Location:** Enter a location code from 0 to 21.

- **Evidence Based Practice / Service strategy:** Enter EBP / SS codes. These fields require leading zeroes.

5. After you have entered defaults, enter "Y" at the Form OK prompt. The system validates data and prompts you to correct any errors.

6. Now, you can use the defaults to enter up to 20 services using the default information. The information you entered in the default box is displayed automatically as you enter data in the screen's service entry lines. You can modify the default data, if necessary,

or just press Tab to accept the default value and move to the next field. At the end of each line you want to save, you must enter "W" to write the service.

```
               Multiple  Service  Entry

        INDIVIDUAL                        RU: 99991  PSP OPT
        SMITH, DONLEY


                             Service              Co
        Client               Date     Proc Staff Dur Staff  Dur Group Loc
                          ───── Defaults ─────
        1000058 TEST CASE, TRACY  6 /7 /2006 341 55555 2 :        :    1    1

        1000058 TEST CASE, TRACY  6 /7 /2006 341 55555 2 :        :    1    1
        1000058 TEST CASE, TRACY  6 /7 /2006 341 55555 2 :        :    1    1
        1000058 TEST CASE, TRACY  6 /7 /2006 341 55555 2 :        :    1    1
        1000058 TEST CASE, TRACY  6 /7 /2006 341 55555 2 :        :    1    1
        1000058 TEST CASE, TRACY  6 /7 /2006 341 55555 2 :        :    1    1
        1000058 TEST CASE, TRACY  6 /7 /2006 341 55555 2 :        :    1    1
        1000058 TEST CASE, TRACY  6 /7 /2006 341 55555 2 :        :    1    1

        Evidence-Based Practices/Service Strategies: 09


   Form OK Y/N:              Confidential Information      User: COHEN_ET
```

7. When you are done entering service data, press Enter to move to the Form OK prompt and enter "Y" to accept the data. After the system validates the data, enter "Y" at the Confirm prompt to save the data.

The screen is cleared and the cursor moves back to the defaults line, so you can enter additional services or change the defaults.
You can imagine how useful this screen would be, for example, if you had to enter the same service for a client for a large number of service dates. You could just change the date and accept the defaults for all the other fields.

Ancillary Service Entry

The Ancillary screen is used to enter ancillary services, such as radiology or laboratory services, that hospitals provide to mental health clients in an inpatient facility. If your county charges for ancillary services separately from the bed day, you must enter them in this screen so they appear on claims. The screen also collects additional patient information used to meet state and federal reporting requirements for inpatient facilities.

Maintaining Direct Services

To maintain direct services:

1. Choose SERVICES from the Main Menu.
2. Choose MANAGEMENT from the Service Maintenance Menu to display the Service Maintenance Selection Screen.

3. To display a list of services, enter:

- **Client Number:** You must enter the number of the client who received the services.

- **Reporting Unit:** To narrow the search, you may also enter a Reporting Unit number.

- **Service Date:** To narrow the search, you may also enter a complete date or a partial date that is just a month or year. If you leave out the year, the system uses the current year.

```
          Service Maintenance Selection


              Client Number:  ████████
              Reporting Unit:
              Service Date:    /  /

    Service                                            Time   Service
    Date        Reporting Unit   Procedure   Therapist  HH:MM  Cost

       -   -
       -   -
       -   -
       -   -
       -   -
       -   -


                   Confidential Information    USER: SMITH
```

4. The Screen displays the Client Name and all the services for the client that match the criteria entered, listed with the most recent services first . Move through the list and Enter "L" (lookup), "D" (delete), or "U" (update) next to the services you want to maintain.

```
           Service  Maintenance  Selection


          Client Number: 500000045    JERSEY        GLASS
          Reporting Unit:
          Service Date:     /  /

     ┌──────────────────────────────────────────────────────────────┐
     │   Service                                       Time  Service │
     │   Date      Reporting Unit      Procedure    Therapist  HH:MM    Cost    │
     ├──────────────────────────────────────────────────────────────┤
     │ ▌31-Mar-87  PSP Crisis 999904 CRISIS      370 GORODEZKY  03:00   75.00  │
     │  27-Mar-87  PSP Clinic 999909 INDIVIDUAL 340 KOSINSKY   01:00   50.00  │
     │  26-Mar-87  PSP Clinic 999909 INDIVIDUAL 340 KOSINSKY   01:00   50.00  │
     │  25-Mar-87  PSP Clinic 999909 INDIVIDUAL 340 KOSINSKY   01:00   50.00  │
     │  22-Mar-87  PSP Crisis 999904 CRISIS      370 SMITH      03:00   75.00  │
     │  19-Mar-87  PSP Clinic 999909 INDIVIDUAL 340 GORODEZKY  02:00   50.00  │
     └──────────────────────────────────────────────────────────────┘


                    Confidential Information         USER: SMITH
   6 services displayed.
```

5. You may select up to 24 services. When you are done, press Enter to display
them for maintenance.

```
           Service  Maintenance  Selection


          Client Number: 500000045    JERSEY        GLASS
          Reporting Unit:
          Service Date:     /  /

     ┌──────────────────────────────────────────────────────────────┐
     │   Service                                       Time  Service │
     │   Date      Reporting Unit      Procedure    Therapist  HH:MM    Cost    │
     ├──────────────────────────────────────────────────────────────┤
     │ U 31-Mar-87 PSP Crisis 999904 CRISIS      370 GORODEZKY  03:00   75.00  │
     │ L 27-Mar-87 PSP Clinic 999909 INDIVIDUAL 340 KOSINSKY   01:00   50.00  │
     │ D 26-Mar-87 PSP Clinic 999909 INDIVIDUAL 340 KOSINSKY   01:00   50.00  │
     │   25-Mar-87 PSP Clinic 999909 INDIVIDUAL 340 KOSINSKY   01:00   50.00  │
     │   22-Mar-87 PSP Crisis 999904 CRISIS      370 SMITH      03:00   75.00  │
     │   19-Mar-87 PSP Clinic 999909 INDIVIDUAL 340 GORODEZKY  02:00   50.00  │
     └──────────────────────────────────────────────────────────────┘


                    Confidential Information         USER: SMITH
   6 services displayed.
```

Direct Service Lookup

If you entered "L" next to a service, it is displayed in the Service Look-up screen.
The data cannot be changed.

```
                    Service  Look-up


   TRACY        TEST CASE                        PSP OPT
   Client:   1000058                             RU: 99991


   Last Changed: 01-Jun-2006 Cost:  $450.00
   Service Stamp: 01-Dec-2003
  ┌──────────────────────────────────────────────────────────────┐
  │      Service Date: 11/3 /2003         Procedure: 341 INDIVIDUAL│
  │   Staff:    55555     Staff Duration:    2 :30    Number in Group: 1│
  │   Co-Staff: 0         Co-Staff Duration: 0 :0     Location: 1  │
  │   Billing_code:              Modifier_1:       Modifier_2:     │
  │   Evidence-Based Practices/Service Strategies: 99             │
  └──────────────────────────────────────────────────────────────┘




      Continue: Y              Confidential Information      USER: COHEN_ET

  Press <Return> to continue.
```

In addition to the data in the Service Maintenance selection screen, this screen displays:

- **Last Changed:** The date that the displayed record was last modified by a user or system program.

- **Cost:** The amount charged for the displayed service.

- **Service Stamp:** The date that the service was originally entered into the system.

Press Enter to display the next record selected in the Service Maintenance Selection Screen. Type "N" and press Enter to go back to the Service Maintenance Selection Screen.

Direct Service Delete

If you entered "D" next to a service, it is displayed in the Service Delete Screen. If you are authorized, you can enter "Y" at the Delete OK prompt and "Y" again to confirm the deletion.

```
                    Service  Delete


  TRACY        TEST CASE                         PSP OPT
  Client:   1000058                              RU: 99991

  Last Changed: 01-Jun-2006 Cost:  $450.00
  Service Stamp: 01-Dec-2003
  ┌──────────────────────────────────────────────────────────┐
  │       Service Date: 11/3 /2003        Procedure: 341 INDIVIDUAL │
  │    Staff:     55555     Staff Duration:    2 :30     Number in Group: 1 │
  │    Co-Staff: 0          Co-Staff Duration: 0 :0      Location: 1 │
  │    Billing_code:               Modifier_1:       Modifier_2: │
  │    Evidence-Based Practices/Service Strategies: 99 │
  └──────────────────────────────────────────────────────────┘




  Delete OK: █              Confidential Information        USER: COHEN_ET
```

If a service has been posted in the billing system, the service may not be deleted
unless you have the correct authorization. If this occurs, tell your supervisor.

Direct Service Update

If you entered "U" next to a service, it is displayed in the Service Update Screen.
If a service has not been processed and you are authorized, you can Tab through
the fields and edit them:

- You can change Staff, Co-Staff, Duration, Number in Group, Location and
  EBP/SS.

- You cannot change Client Number, Reporting Unit Number, Last Changed
  Date, Service Cost, or Service Stamp.

- If you have supervisor authorization, you can change Service Date and
  Procedure.

If the service has already been billed to the client or to a third party payor, you
cannot change some fields through this screen without making an adjustment to
the client's account. If a service cannot be changed through this screen, the cursor

automatically moves to the Form OK prompt.

You can press Enter at any time to move to the Form OK prompt. Enter "Y" to save the changes. The system validates the data before saving it.

```
                    Service Update


  TRACY         TEST CASE                         PSP OPT
  Client:   1000058                               RU: 99991

  Last Changed: 01-Jun-2006 Cost:  $450.00
  Service Stamp: 01-Dec-2003

  ┌──────────────────────────────────────────────────────────────┐
  │     Service Date: 11/3 /2003        Procedure: 341 INDIVIDUAL  │
  │   Staff:    55555     Staff Duration:    2 :30    Number in Group: 1 │
  │   Co-Staff: 0         Co-Staff Duration: 0 :0     Location: 1  │
  │   Billing_code:                Modifier_1:        Modifier_2:  │
  │   Evidence-Based Practices/Service Strategies: 99 51 10        │
  └──────────────────────────────────────────────────────────────┘





      Form OK:              Confidential Information       USER: COHEN_ET


```

Late Entry, and Supervisor Authorization

Late Entry and Supervisor Authorization are available in all three of the Maintenance Screens.

In the Update screen, Supervisor Authorization lets you change Service Date and Procedure.

In the Lookup and Update Screens, Supervisor Authorization lets you view these additional fields:

- **Service/Client Acct:** The Service and/or Client Account to which this service has been billed. Because of Client Merge Adjustments and other Client/Account Adjustments the service could be posted to an Account different from the Client's current Account.

- **Posting Status:** The service status within the billing system.

- **UR Status:** Whether or not this service has been authorized by a Utilization Review Action. Unauthorized services are "99".

```
                    Service Update
                     Supervisor

   TRACY        TEST CASE                        PSP OPT
   Client:    1000058                            RU: 99991


   Last Changed: 01-Jun-2006 Cost:  $450.00
   Service Stamp: 01-Dec-2003 05:07:36.39

   ┌─────────────────────────────────────────────────────────────┐
   │       Service Date: 11/3 /2003       Procedure: 341 INDIVIDUAL│
   │    Staff:    55555    Staff Duration:    2 :30    Number in Group: 1│
   │    Co-Staff: 0          Co-Staff Duration: 0 :0    Location: 1 │
   │    Billing_code:                  Modifier_1:      Modifier_2: │
   │    Evidence-Based Practices/Service Strategies: 99             │
   └─────────────────────────────────────────────────────────────┘

   Serv./Client Acct:      1011/    1011 Orig.  FRC: 0    Clearances: 1
   Posting Status: 0                     Potent FRC: 0    Screen Source: 17
   UR Status:      0                     Tried  FRC: 0    CDS Date:
   UR Posted:                            Actual FRC: 0
   Component UID:                        Episode Stamp: 03/01/2001 13:55:27.86

      Form OK:              Confidential Information        USER: COHEN_ET

  Input required
```

- **UR Posted:** The date when Utilization Review action authorized the service. You
  can use this date to find the correct UR Action using the UR Status Inquiry Screen.

- **Component UID:** The identification number for this service if it is a contact-based
  service entered on the Component Service Entry Screen.

- **Original FRC:** All payor sources (Medicaid, Medicare, County, Insurance, Patient)
  that can be billed for this type of service in your system.

- **Potential FRC:** All payor sources (Medicaid, Medicare, County, Insurance, Patient)
  that can be billed for this particular service.

- **Tried FRC:** Payor sources (Medicaid, Medicare, County, Insurance, Patient) that
  you have tried to bill for the service.

- **Actual FRC:** Payor sources (Medicaid, Medicare, Short-Doyle, Insurance, Patient)
  that have actually been billed for the service.

- **Episode Stamp:** The Episode to which the Service is attached. Episodes can be
  positively identified by their Key Entry Date which is referred to here as Episode
  Stamp.

- **Clearances:** The Clearances Flagword in the database. This code will identify
  which systems have processed this service (POSTING, BILLING, CDS, UR, POE).

- **Screen Source:** The screen used to enter the service.

- **CDS Date:** The date the service was reported to the state.

In the Delete Screen, the Supervisor Authorization lets you delete a service that has been posted by the billing system. In this case, the Delete Screen deletes the service and also writes an adjustment to the client's account. Supervisor Authorization alone does not allow you to delete a service that has been claimed to a payor source: you must also have additional authorization.

To use late entry and Supervisor authorization:

1. Display the Service Lookup, Delete or Update screen.
2. Press Num Lock-A to display the screen in Late Entry mode, to enter data for a time period whose deadline has passed.

3. Press Num Lock-A a second time to display the screen in Supervisor mode.
4. Press Num Lock-A a third time to display the screen in both Supervisor and Late Entry mode.

San Bernardino County Department of Behavioral Health
Universal Charge Data Invoice (CDI) – Mental Health Program Outpatient Services

Clinic Name: _____ **Reporting Unit:** _____ **Service Date:** _____ **Primary Staff No.** _____

Client Number	Client Name / Activity	Proc Code	Gp Count	Primary Staff Time	Co-Staff Number	Co-Staff Time	Svc. Loc.	EBP/SS	Clk. OK
				:		:			
				:		:			
				:		:			
				:		:			
				:		:			
				:		:			
				:		:			
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				:		:			
				:		:			
				:		:			
				:		:			

Universal CDI Code Set by Type (as of 1 July 2006)

Administrative Codes

300	No Show
302	No Show Walk-In
304	Rescheduled
305	Clinic Canceled
306	Patient Canceled Walk-In
307	Appt Rescheduling
309	Patient Canceled
403	Leave and Holiday
404	Training Given
405	Training Received
406	Dept Travel Time
407	Local Meeting
408	Departmental Meeting
409	Interagency Meeting
410	Other Meeting
418	Approved Special Assignment
419	Administrative Duties NOS
457	Clinical Supervision Provided
458	Clinical Supervision Received
459	Admin Supervision Provided
460	Admin Supervision Received

Assessment Codes

331	Assessment
332	Assessment AB2726
333	Assessment Walk-In
334	Assessment Hosp Aftercare
337	Assessment Telmed
684	Assessment Healthy Homes

CalWORKs Codes

310	Collateral
320	Psych Testing
330	Assessment
340	Family Therapy
340	Individual Therapy
350	Group Therapy
360	Medications
370	Crisis Intervention
520	MHS Plan Development
550	Rehab/ADL

Case Management Codes

541	Placement Service
542	Placement Services AB2726
544	Placement Hospital Aftercare
561	Linkage & Consultation
562	Linkage & Consultation AB2726
564	Case Mgmt Walk-In
566	Link/Cons Hospital Aftercare
567	Linkage Telmed
571	Plan Development Case Mgmt
572	Plan Development AB2726
574	Plan Devel CM Hosp Aftercare
579	Plan Devel CM AB2726
693	Healthy Homes Placement

Collateral Codes

311	Collateral
312	Collateral AB2726
313	Family Collateral
314	Collateral HAS
315	Collateral
316	Collateral Walk-In
317	Collateral Telmed
681	Collateral Healthy Homes
683	Family Colll Healthy Homes

Conservatorship Invest

621	Conservatorship Invest
631	Conservatorship Admin

Crisis Intervention Codes

371	Crisis Intervention
372	Crisis Intervention AB2726
373	Crisis Walk-In
377	Crisis Telmed
688	Crisis Healthy Homes

Day Treatment Codes

286	Half Day Intens Day Tx AB
291	Day Tx Habil Half Day
292	Day Care Habil AB2726
295	Day Tx Habil Full Day
296	AB Day Tx Habil Full

Group Billing Codes

351	Group
351	Family Group
352	Group AB2726
686	Group Healthy Homes

Individual Therapy Codes

341	Individual
341	Family/Individual
342	Individual AB2726
347	Individual Telmed
685	Individual Healthy Homes

Indirect (non-billed) Services

411	Mental Health Promotion Adult
412	MH Promotion AB2627
417	Mental Health Promotion Child
420	AB2627 Mediation/Due Process
421	Community Client Contact Adult
422	CC Contact AB2726
423	Interpretation Services
427	Community Client Contact Child
433	DT Tx Support Adult
434	DT Tx Support AB2726
437	DT Tx Support Child
442	Classroom Observation
452	I.E.P.
461	Placement Evaluation
462	Hospital Liaison
463	Court Appearances
661	Case Mgmt Support

Medication Support Codes

361	Medication
362	Medication AB2726
363	Medication Walk-In
367	Meds via Telmed
687	Meds Healthy Homes

MHS Plan Development Codes

521	Plan Development
522	Plan Development AB2726
524	Plan Devel.Hospital Aftercare
691	Plan Development Healthy Homes

Psych Testing Codes

321	Psych Testing
322	Psych Testing AB2726

Quality Assurance Codes

395	QA Case Review/Direct
451	Non Medi Cal QA Chart Audit
454	MediCal QA Chart Audit
455	QA Committee Meeting/Indirect
456	QA Administration/Indirect

Rehab/ADL Codes

551	Rehab/ADL
552	Rehab/ADL AB2726
554	Rehab/ADL Hospital Aftercare
557	Rehab ADL Telmed
695	Rehab/ADL Healthy Homes

Unbilled Direct Service Codes

339	Assessment AB2627 NBC
330	Assessment NBC
310	Collateral NBC
319	Collateral AB2627 NBC
620	Conservatorship Investigation
379	Crisis Inter AB2627 NBC
370	Crisis Intervention NBC
539	Emergency Inter AB2627 NBC
530	Emergency Intervention NBC
519	Evaluation AB2726 NBC
510	Evaluation NBC
359	Group AB2627 NBC
350	Group NBC
349	Individual AB2726 NBC
340	Individual NBC
402	Intake No Show AB2726
289	Intens Day Tx AB2627 NBC
569	Linkage & Advocacy AB2726 NBC
560	Linkage & Consultation NBC
360	Medication NBC
369	Medication AB2627 NBC
549	Placement Services AB2726 NBC
540	Placement Services NBC
529	Plan Development AB2726 NBC
570	Plan Development Case Mgmt
520	Plan Development NBC
329	Psych Testing AB2627 NBC

Evidence-Based Practices/Service Strategies EBP/SS

01	Assertive Community Treatment (ACT)
02	Supportive Employment
03	Supportive Housing
04	Family Psychoeducation
05	Integrated Dual Diagnosis Treatment
06	Illness Management
07	Medication Management
08	New Generation Medications
09	Therapeutic Foster Care
10	Multisystemic Therapy
11	Functional Family Therapy
50	Peer and/or Family Deliverd Services
51	Psychoeducation
52	Family Support
53	Supportive Education
54	Delivered in Paternship with Enf Law Enforcement
55	Delivered in Partnership with Health Care
56	Delivered in Partnership with Social Services
57	Delivered in Partnership with Substance Abuse Services
58	Integrated Services for Mental Health
59	Integrated Services for Mental Health And developmental Disability
60	Ethnic-Specific Service Strategy
61	Age-Specific Service Strategy
99	Unknown Evidence-Based Practice/Service Strategy

Service Location Codes

1	DBH Site
2	Field/OOC
3	Non Face-to-Face Service
4	Home
5	School
6	Satellite
7	[Not Used]
8	Jail
9	Inpatient
10	Homeless
11	Faith-based (Church,temple,etc)
12	Health Care/Primary Care
13	Age Specific Community Center
14	Client's Job Site
15	Licensed Care Residential Adult
16	Mobile Service
17	Non-traditional service location
18	Other Community location
19	Residential Care/Facility/Community Treatment Facility
20	Telehealth

696	Link/Consultation Healthy Homes	662	Case Mgmt Support AB2726	320	Psych Testing NBC
697	Plan Devel CM Healthy Homes		TBS Service	559	Rehab/ADL AB2627 NBC
		581	Therapeutic Behavioral Service	550	Rehab/ADL NBC

GENERAL INSTRUCTIONS

Universal Charge Data Invoice (CDI)- Mental Health Services

Revised July 1, 2006

The Charge Data Invoice (CDI) provides data relevant to services that have been provided so that billing or other cost allocation may be done. All services and CDI categories are now combined on a single page.

The CDI is completed for each workday and is submitted no later than the next day.

Information provided on the CDI must be accurate. It is unethical to distort information provided on the CDI. Inaccuracies may be viewed by the Department's Compliance Unit and by the Federal government as fraud.

See Outpatient Chart Manual Section 11 for detailed billing information. For exact service definitions, see DBH Service Function/Scope of Practice Summary and DBH MAA definitions.

A listing of common procedure codes in use as of Nov 2004 is on the second page of the universal CDI and may be printed on the back of the CDI if desired.   A current and complete listing is also available in the CDI Code Summary on the clinical_rec site.

Please note: Day Treatment billing is done using a printout from SIMON and is not included on this Universal CDI.

ENTRIES:
1. Clinic Name
2. Reporting Unit in SIMON used as tracking number for site or service type
3. Service Date is the date the billed service occurred
4. Primary Staff Number is the SIMON staff number of the primary service staff.
5. Client Number is the SIMON registration number of client.
6. Client Name as it appears in medical record.
7. Procedure Code - enter the procedure code for the service provided as identified in the chart note heading. Service type abbreviations on the CDI are the chart note headings that are to be used in chart notes. Please note that the same procedure code number is used in some cases for more than one service — e.g., 551 MHS-Rehab/ADL-Ind. and 551 MHS-Rehab/ADL-Grp.
8. Group Count is the number of clients in a group.
9. Primary Staff Time is the time spent on the service, related Plan Development, and charting for that service by the primary staff person, to the minute as near as possible — i.e., 1:26, 0:14 etc.; same as time entered on interdisciplinary note in chart for that person for that service.
10. Co-Staff Number is the SIMON number of co-staff if there was a co-staff for the service.
11. Co-Staff Time was time spent on the service, related Plan Development, and charting for that service by the co-staff person, to the minute as near as possible — i.e., 1:26, 0:14, etc.; same as time entered on interdisciplinary note in chart for that person for that service.

12. <u>Service Location</u>. Please see service location codes back of CDI or on chart forms. Must be same service location as entered on interdisciplinary note in chart for that service. For MAA service, please enter one of the two MAA Provider codes (SPMP provider 9, non-SPMP provider 8).
13. **<u>EBP/SS.</u> Please see Evidence-Based Practices/Service Strategies codes back of CDI. Can enter up to 3 codes.**
14. <u>Clk. OK</u> is a check box used by clerical staff to keep track of data entry lines and/or for checking data entry.
15. <u>Staff signature</u> affirms that all entries meet the requirements of the certification statement.
16. <u>Data Entry Done By</u> and <u>Date Entered</u> for use by clerk entering CDI data into SIMON.

Place of Service / Service Location Codes

1 = Office [formerly "Office (including phone)"]

Definition: Services are provided in a location, other than a hospital, skilled nursing facility (SNF), correctional facility, public health clinic or facility supplying residential care, where the mental health professional routinely provides assessments, diagnosis, and mental health treatment on an ambulatory basis.

2= Field (unspecified) [formerly "Field (when location is away from the clinician's usual place of business, except for Correctional Institution and Inpatient)"].

Definition: Services are provided in an unspecified location away from the clinician's usual place of business, except for Correctional Institution, Inpatient, or Residential Care for adults or children.

3 = Phone

Definition: Services are provided by telephone contact with the client, not involving video conferencing.

4 = Home

Definition: Services are provided at a location, other than a hospital or other facility, where the client receives care in a private residence.

5 = School

Definition: Services are provided in any facility that has the primary purpose of education.

6 = Satellite Clinic

Definition: Services are provided in a location, other than a hospital, skilled nursing facility (SNF), correctional facility, public health clinic or facility supplying residential care, where the mental health professional routinely provides assessments, diagnosis, and mental health treatment on an ambulatory basis.

8 = Correctional Facility (eg., Jail, Prison, camp/ranch, etc.) [Formerly "Correctional Institution"]

Definition: Services are provided in a correctional facility, including adult or juvenile detention facilities.

9 = Inpatient (e.g., Hospital, Psychiatric Health Facility (PHF), Skilled Nursing Facility (SNF), Institute for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC).

Definition: Services are provided in a facility which primarily provides diagnostic, therapeutic, and rehabilitative services. Includes hospitals, psychiatric health facilities (PHF), skilled nursing facilities (SNF), Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRC).

10 = Homeless / Emergency Shelter

Definition: Services are provided in a facility specifically designed to provide shelter to the general homeless population.

11 = Faith-based (e.g., church, temple, etc.)

Definition: Services are provided in a location owned or leased by a faith group, with partial or full involvement of the faith group.

12 = Health Care / Primary Care

Definition: Services are provided by the consumer's primary care or general health care provider, or in the clinic or facility of the health care provider, including emergency room and public health clinics

13 = Age-Specific Community Center

Definition: Services are provided in a location owned or leased by an age-specific community center, such as a senior's center, a teen drop-in center, etc.

14 = Client's Job Site

Definition: Services are provided at the client's site of employment.

15 = Residential Care – Adults

Definition: Services are provided in a location supplying 24-hr non-medical care for adults, not including inpatient hospital, psychiatric health facilities (PHFs), skilled nursing facilities (SNFs), Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRCs), or homeless/emergency shelters. Includes assisted living facilities for adults such as group homes.

16 = Mobile Service

Definition: This definition is consistent with the concept of a Mobile Clinic. Mobile clinics provide services to individuals in rural or outlying areas where services are otherwise inaccessible. The concept of mobile services is in contrast to services provided at other community locations (see other listed service settings) that are reached by vehicle.

17 = Non-Traditional service location (e.g., park bench, on street, under bridge, abandoned building)

Definition: Services are provided in the community, but not in a community center, school, faith-based location, homeless/emergency shelter, health-care center, or the client's job site. Examples include park bench, on the street under a bridge, in an abandoned building, etc.

18 = Other Community location

Definition: Services are provided in the community, but not in a homeless/emergency shelter, a faith-based location, home, the client's job site, a non-traditional service location, an age-specific community center, or school. Also it includes community centers that are not age-specific, non-residential substance-abuse treatment centers etc.

19 = Residential Care – Children

Definition: Services are provided in a location supplying 24-hr non-medical care for children, other than inpatient hospital, or psychiatric health facilities (PHFs). Includes Community Treatment Facilities (CTFs) and family foster homes.

Definition of Community Treatment Facility (CTF): Any residential facility that provides mental health treatment services to children in a group setting which has the capacity to provide secure containment.

20 = Telehealth

Definition: Also known as "Telemedicine." Services are provided so that the clinician and client are in two different locations but can see each other via visual equipment (e.g., video camera, web camera).

21 = Unknown / Not Reported

Indirect Services

Indirect Services are non-client services such as consultation, outreach, overhead time or other non billable activities. They may include presentations to schools, community outreach and public service radio broadcasts.

Indirect Services: Summary Screens

There are two types of Indirect Services Screens in InSyst, Summary screens and Detail screen.

Entering New Indirect Services (Summary)

The Indirect Services Summary screen is used to collect hours of service performed by staff members on behalf of their program. The recipient of the service is not a registered client. You can enter up to 10 services at a time for a single staff member using this screen.

To enter new indirect services using the summary screens:

1. Choose INDIR_SERV from the Main Menu.

2. Choose INDIR_ENT from the Indirect Service Maintenance Menu to display the Indirect Service Entry screen.

3. Enter data in the following fields:

 RU: Enter the Reporting Unit Number for your program. Once the reporting unit number has been validated by the computer system, you keep entering services for this program without re-entering the reporting unit number. To change Reporting Units, press Num Lock-P to move to the RU field and enter a new number.

InSyst

Mental Health
Indirect Service Maintenance Menu

```
Selection: ███████████████████████████████████████████

  Selection        Description

  INDIR_ENT        Indirect Service Summary Entry
  INDIR_MAN        Indirect Service Summary Maintenance
  INDIR_ENT2       Indirect Service Detail Entry
  INDIR_MAN2       Indirect Service Detail Maintenance

V ──────────────────────────────────────────────── V
```

Staff Number: Enter the staff identification number for the person performing the service. The staff number will be validated for authorization to perform the services you are entering.

Procedure: Enter a three-digit procedure code in this field. This screen only accepts services marked as Indirect Services in the Provider Balances table of the system.

Service Date: Enter the service date in the format MM/DD/YY.

Duration: Enter the number of hours and/or minutes for the service.

Recipient: Enter a recipient code to identify the person/agency the service is performed for. This cannot be a registered client in the system.

4. When you are done, press Enter, and enter "Y" at the Form OK prompt to save the changes. The system validates the data. If any is invalid, it displays an error message, and you must use the Tab key to move to the field and correct it. Then it saves the data. The cursor returns to the Staff Number field, so you can enter a new Staff Number and record more services. To enter indirect services for another Reporting Unit, press Num Lock- P to enter a new RU number.

Special Features of the Indirect Service Entry Screen

Authorized staff can use these special features of the Indirect Service Entry Screen.

Late Entry Authorization: Press Num Lock-A once to enter indirect services for a time period that has passed. For example, if data entry for April is closed on May 5, Late Entry authorization lets you enter indirect services after that time.

Supervisor Authorization: Press Num Lock-A twice to override system validations and checks in the Staff, Procedure, Duration, and Recipient fields.

Supervisor and Late Entry Authorization: Press Num Lock-A a third time for both of the above.

To maintain Indirect Service records using the summary screens:

1. Choose INDIR_SERV from the Main Menu.

2. Choose INDIR_MAN from the Indirect Service Maintenance Menu to display Indirect Service Maintenance Selection screen.

3. Enter search criteria in the fields at the top of the screen:

> **RU:** Enter a Reporting Unit number.
> **Staff:** Enter a Staff Number.
> **Procedure:** Optionally, to narrow the search, enter a Procedure Code.
> **Service Date:** Optionally, to narrow the search, enter a Service Date. You can enter a complete date, a month, or just a year. If you leave out the year, the system will assume the current year.

MEDICATION PRESCRIPTON ENTRY

InSyst lets you maintain a history of a client's prescriptions, and produce reports that summarize it. Prescription information is entered through the Medication Management Screens.

To enter new medication prescriptions:

From the Mental Health Main Menu
1. Choose **Clinical** and **MEDICATION** to display the Medication Maintenance Selection Screen.

2. Press Num lock**-I** to insert a new record. The system displays the Medication Insert Screen (shown below). First you must display a list of prescriptions, then add new ones to the list, in the same format as the ones shown. The entry or display box scrolls up as you enter new prescriptions, to let you add more.

3. To display a list of prescriptions, enter data in the fields at the top of the screen:
- **Client Number**: Enter a client number.
- **RU:** Enter your Reporting Unit number.

4. The client does not need to have an open episode at your reporting unit. After checking the client number, the screen displays the client name, birth date, sex and age, to help verify that you are entering a prescription for the right client. If the client has previous prescriptions, the screen displays the three most recent.

5. To enter a new prescription, use the Down Arrow key to move to a blank entry line, and enter data in the following fields:

- **Order Date**: Enter the date of the prescription.
- **Drug**: Enter the name and strength of the drug. (Drug names in this system include strength: for example, AMITRIPTYLINE 10 mgm is one drug and AMITRIPTYLINE 50 mgm is another drug.) In general you enter a drug code rather than a drug name. If you enter the first few letters of the name, the screen will display drugs that begin with those letters, so you can select a drug code and name.
- **Quantity:** Enter the number of drug doses in the prescription. For example, if the doctor prescribes a total of 50 aspirin tablets, the quantity is 50.
- **Dose:** Enter the size of each dose. For example, two aspirins three times a day is a dose of 2.
- **SIG:** Enter the Frequency Code. For example, if the patient is to take the medication twice a day, the physician writes the SIG code "BID" on the prescription. (Some SIG codes are listed below.)
- **Refill:** Enter how many refills are allowed.
- **Staff:** Enter the physician's ID number.

6. If you do not know the drug code, enter the first few letters of the drug name. For example "AMI" for AMITRIPTYLINE. The lower section of the screen will display drugs beginning with AMI. Then press the Tab key to move to this section, and select the drug name by typing "X" next to it. The screen will enter that drug and return the cursor to the next field for data entry. Report MHS 242 is a complete listing of drugs and drug codes.

7. When you have entered a prescription record, the cursor moves to the next line to enter another. If you are done entering prescriptions, press Return, and then enter "Y" at the confirmation prompt.

Your system manager should have a list of local SIG Codes (Frequency Codes). Contact your supervisor before entering a SIG code not on the local list.

SIG Codes

?

AT DINN at dinner
AT LUNC at lunch
BID N times daily
BIDPRN 2 daily as needed
HS at bedtime
HS,PRN at bedtime as needed
PRN as needed
Q12H every 12 hours
Q12HPRN every 12 hours as needed
Q14D Every 2 Weeks

Q2H every 2 hours
Q2HPRN every 2 hours as needed
Q3H every 3 hours
Q3HPRN every 3 hours as needed
Q4H every 4 hours
Q4HPRN every 4 hours as needed
Q6H every 6 hours
Q6HPRN every 6 hours as needed

Q7D Every Week
Q8H every 8 hours
Q8HPRN every 8 hours as needed
QAM in the morning
QD Daily
QDPRN daily as needed
QHS at bedtime
QID 4 times daily
QIDPRN 4 daily as needed
QOD Every other day

- **Q#H:** every # hours (for example, Q2H means "every two hours")
- **PRN:** as needed (can be used with other SIGs. For example Q3HPRN means "every three hours as needed" and HSPRN means "at bedtime as needed".)
- **SPECIAL**: complex instructions with no standard frequency code

As you have seen, the Medication Insert screen lists the last three prescriptions for the patient.
To enter a refill:
1. Display the Medication Maintenance Selection Screen and press Num lock-I to display the Medication Insert screen, as described above.

2. Type "X" next to the prescription being reordered. Change the Order Date and any other information that has been changed (such as a different dose). Then press Return to complete your entry.

This refill feature creates a new prescription record. It does not alter existing records.

Maintaining Prescriptions

To maintain existing prescriptions,
1. Choose MEDICATION from the Clinical Menu to display the Medication Maintenance Selection Screen, as described above.

2. To locate the prescription, enter a Client Number. You can limit the search by also entering an Order Date Range and Staff Number. Press Return to display the client's past prescriptions with the most recent first (See below).

3. To select prescriptions for maintenance, press Tab to move the cursor through the list. Type "U" (update), "L" (lookup), or "D" (delete) next to prescription records you want to maintain.

Medication Maintenance Selection Screen

Prescription Lookup
If you entered "L" next to a prescription, it is displayed in the Medication Lookup screen, which displays the prescription and also:

- **Reporting Unit:** The reporting unit where the prescription was written.
- **Drug Code:** The drug code for the drug name used in the prescription.
- **Entered On:** The date the prescription was entered in to the system.
- **Staff Name:** The full name of the physician.
- **Changed On:** The last date the prescription was modified.
- **Changed By:** The name of the user who last entered or changed this

prescription record.
You can view this data but not alter it.

Prescription Delete
If you entered "D" next to a prescription, it is displayed in the Medication Delete screen. Enter "Y" at
the Delete OK prompt and "Y" again at the confirm prompt to delete the record.

Prescription Update
If you entered "U" next to a prescription, it is displayed in the Medication Update screen, which has
the same fields as the Lookup screen. Tab through the fields and change them as needed.

PASSWORDS

When you log on to the computer system, you must enter your Username and your Password. Passwords are vital to system security. Passwords expire every six (6) weeks. Two or three days earlier, you will receiving warnings that your Password is about to expire.

To change your Password:
1. Choose **UTILITIES** from the Main Menu.
2. Choose **PASSWORD** from the Utilities Menu to display the Password Menu. This has only two options: Primary Password and Secondary Password.

You have only one password, the Primary Password.

To change your Primary Password:
1. Choose **PASSWORD** from the Utilities Menu.

2. Choose **Primary Password** from the Password Menu.

3. The system displays the prompt: **CHANGE PRIMARY LOGON PASSWORD Allow system to generate a password? <yes>:** If you enter "Yes" or press Return, the system will asks you for your old password and then displays a list of nonsense words. You can use one of these options as your password or ask the system to generate another list of words. If you enter "No", the system lets you enter your own new password later.

4. The system displays the prompt: **Old Password:** Enter your current Password.

5. The system displays the prompt: **New Password:** Enter your new password.

6. The system displays the prompt: **Verification:** Re-type your new password. If this is not the same as the new password you entered originally, the system displays the message "password verification error", and returns you to the previous menu. To change your password, you must start again.
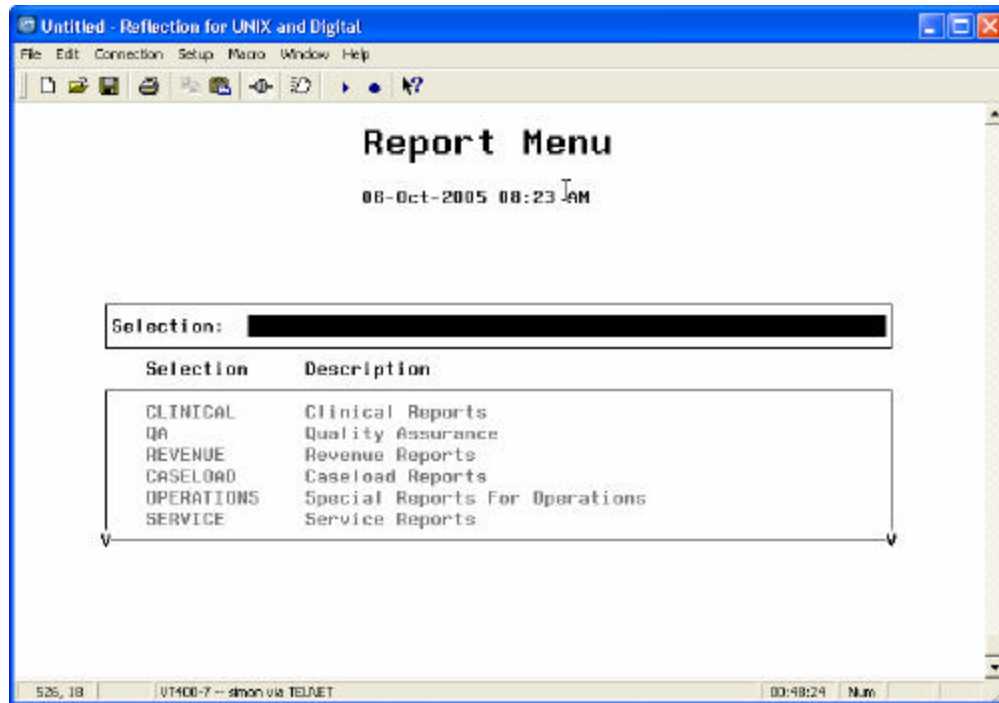
Passwords that you type are not displayed on the screen. After you change your password successfully, you are returned to the previous menu with no message.

CREATING A REPORT

This function does NOT print the report; when the report is complete, see instruction on printing queues.

FROM THE MAIN MENU:

    1.   Select **RE**ports <return>

    2.   Select type of report:
                    ACcount
                    CAseload
                    CLinical
                    INsurance
                    OPerations
                    QA
                    REvenue
                    SErvice <return>
    3.   Select report by number (i.e., MHS502) <return>
    4.   Answer the question the system asks with the return being the default.
    5.   When you have answered all the questions, the system will tell you the report number and status. <return>

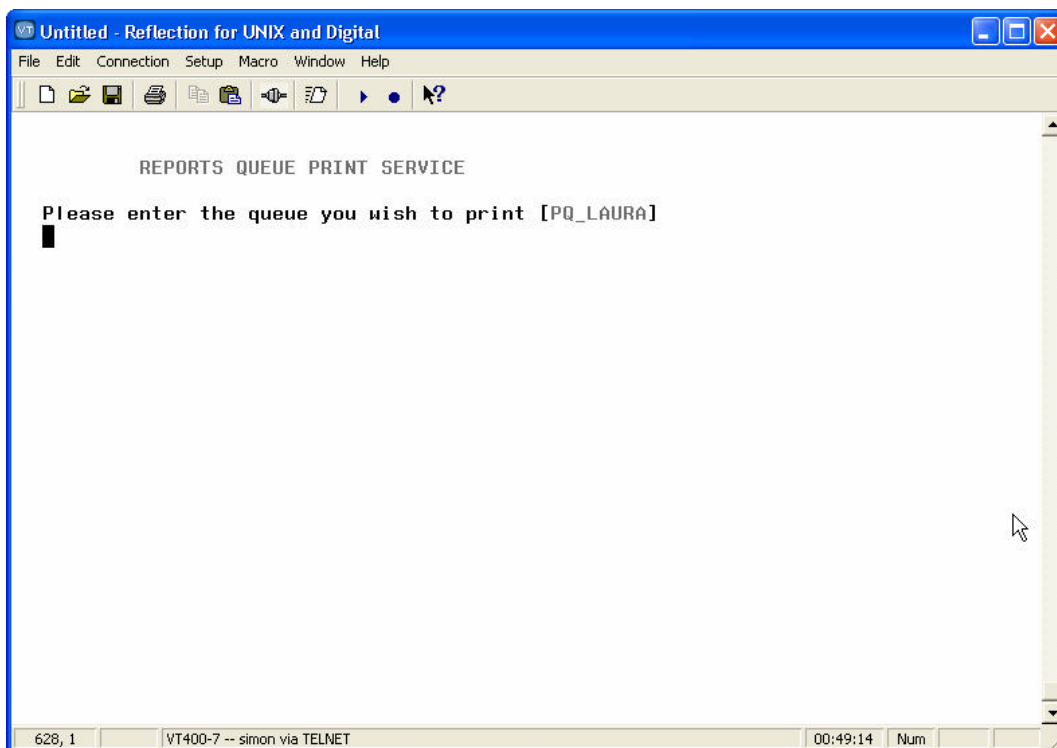This completes the creation of a report.

PRINTING QUEUES

Creating a report and printing a report are two separate and distinct functions in the SIMON system.

FROM THE MAIN MENU:

1. Select **UT**ilities <return>
2. Select **TO**ols <return>
3. Select **QU**eues <return>
4. Type in the name of the Queues (i.e., pq_face <return>
   Answer all questions to
5. Numlock-E

The printer will start to print.

Print Queue's are not tied to any location, printer or person. You can print reports from any printer for any queue.

```
VT  Untitled - Reflection for UNIX and Digital                          _ □ ✕
File  Edit  Connection  Setup  Macro  Window  Help

  D  📂  🖫  🖨  📋  📋  ◁▯◁  ⫼🗐  ▶  ●  ▶?


             REPORTS QUEUE PRINT SERVICE

     Please enter the queue you wish to print [PQ_LAURA]
     █








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<Your 'TELNET' connection has terminated>

CDI MENTAL HEALTH DEFINITIONS

ASSESSMENT
> Assessment is a clinical analysis of the history and current status of Individual's mental, emotional, or behavioral disorder. Relevant cultural issues and history may be included where appropriate. Assessment may include re-assessment diagnosis and the use of testing procedures.

CANCEL**
> **.**   **CLINIC** When the clinic cancels the appointment.
> **.**   **PATIENT**   When the patient cancels the appointment.

COLLATERAL
> Contact with one or more significant support persons in the life of the Individual that may include consultation and training to assist in better utilization of services and understanding mental illness. Collateral services include, but are not limited to, helping significant support persons to understand and accept the Individual's condition and involving them in service planning and implementation of service plan(s). Family counseling or therapy that is provided on behalf of the Individual without the Individual present is billed as a collateral. (also see Individual / Family Therapy)

COURTROOM APPEARANCES ****
> Used by CONREP ONLY. By subpoena.

CRISIS INTERVENTION
> Crisis Intervention is a quick emergency response service enabling the Individual to cope with a crisis, while maintaining his/her status as a functioning community member to the greatest extent possible. A crisis is an unplanned event that results in the individual's need for immediate service intervention. Crisis Intervention services are limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization, which is provided in a 24-hour health care facility or hospital outpatient program.

COMMUNITY CLIENT CONTACT*
> Activities directed toward:
> **.**   Assisting individuals and families for whom there is no open case record to achieve a more adaptive level of functioning through single contact or occasional contact.
> **.**   Enhancing or expanding the knowledge and skills of human service agency-staff in meeting the needs of mental health clients.

CONSERVATORSHIP INVESTIGATION*
> Services provided by a designated investigator or agency to:
> .   Collect, assess, and document for the court of jurisdiction the psychosocial and financial information necessary to support or deny a
>
> finding of grave disability consistent with established LPS criteria.
> .   Evaluate the feasibility of available alternatives to Conservatorship.
> .   Make a recommendation to the court regarding Conservatorship status.

DAY REHABILITATION
> Day Rehabilitation provides evaluation, rehabilitation and therapy to maintain or restore personal independence and functioning consistent with requirements for learning and development. It is an organized and structured program, which provides services to a distinct group of individuals. Day Rehabilitation is a packaged program with service available at least three hours for half-day or more than four hours for full day and less than 24 hours each day the program is open.

DT TREATMENT SUPPORT**

The amount of time staff is assigned to a day treatment program.

DRUG SCREENING**
Used by CONREP ONLY. Obtaining a urine sample from each patient at scheduled and unscheduled times and submission for analysis to the conrep statewide contract Lab.

EVALUATION
Evaluation is appraisal of the individual's community functioning in several areas including living situation, daily activities, social support systems and health status. Cultural issues may be addressed where appropriate.

EDUCATION / TRAINING*

The training and educational activities must be closely and clearly related to the individual's care and treatment. This is a DAY REHABILITATION activity for MEDICARE.

INDIVIDUAL / FAMILY THERAPY**
Family Therapy is considered an Individual Family if the client is present. Family Therapy is billed as collateral if the client is not present. (also see COLLATERAL)

GROUP / FAMILY THERAPY *
Services designed to provide goal-directed face-to-face therapeutic intervention with a family if more than one family member present has an open chart who are treated at the same time and which focus on their mental health needs.

HOSPITAL LIAISON**
Used by CONREP ONLY. Upon referral the lead program shall provide all relevant information about the patients known community treatment history to the state hospital during the course of inpatient treatment. The liaison service includes consultation with hospital staff and regular visits
. These are necessary to coordinate treatment and planning for community placement.

INDIVIDUAL *
Services designed to provide a goal-directed face-to-face therapeutic intervention with the client individually which focuses on the mental health needs of the client.

INTAKE NO SHOW **
When a potential client does not show for the initial intake session.

LINKAGE AND CONSULTATION
The identification and pursuit of resources necessary and appropriate to implement the Client Plan, Care Necessity Form, which include but are not limited to the following:
.	Interagency and intra-agency consultation, communication, coordination, and referral.
.	Monitoring service delivery and Client plan, Care Necessity Form to ensure an Individuals access to service and the service delivery system.

MEDICATION SUPPORT SERVICES
Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness which are provided by a staff person, within the scope of practice of his/her profession.

MH PROMOTION*
Mental Health Service activities directed toward:
. Enhancing and/or expanding agencies' or organizations' knowledge and skills in the mental health field for the benefits of the community-at-large or special population groups.
. Providing education and/or consultation to individuals and communities regarding mental health service programs in order to prevent the onset of mental health problems.

NO SHOW**
For clients that neither cancel nor reschedule their appointments and do not show up, also use this no-show for AB3632 clients.

PLACEMENT EVALUATION***
Used by CONREP ONLY. Evaluating the clients needs for a level of care.
The Conrep program evaluates the person to determine the most appropriate treatment facility or site. The evaluation must encompass at a minimum, Review of legal, medical documents and consideration of both clinical and security needs.

PLACEMENT SERVICES

Supportive assistance to the client in the assessment, determination of need and securing of adequate and appropriate living arrangements in a licensed facility including, but not limited to the following:
. Locating and securing an appropriate licensed living environment.
. Locating and securing funding.
. Pre-placement visit(s)
. Negotiation of housing or placement contracts.
. Placement and placement follow-up.

PLAN DEVELOPMENT
Plan Development may include any or all of the following:
. Development of Client plans, Care Necessity forms.
. Approval of plans
. Verification of medical or service necessity
. Monitoring of the Individual's progress.

PSYCHOLOGICAL TESTING**
Test administration, test scoring, test interpretation, and report writing. There is no limit on the number of billings per battery or on total time. Licensed Psychologist or psychology intern only.
(Every billing entry should have a supporting chart note.)

REHABILITATION / ADL

>   This service may include any or all of the following:
>
>   .   Assistance in restoring or maintaining an Individual's or group of Individuals functional skills, daily living skills, social skills, grooming and personal hygiene skills, meals preparation skills, medication compliance and support resources.
>   .   Counseling of the Individual and/or family.
>   .   Training in leisure activities needed to achieve the individual's goals/desired results/personal milestones.
>   .   Medication education.

RESCHEDULE**

>   When either the patient or the clinic reschedules the visit within 24 hours of the scheduled visit.

VOCATIONAL**`

>   This is used to track the Vocational Grant. See SPM "Vocational Programs Time and Attendance and Charge Data Invoice (CDI) Reporting" for details.

DEFINITIONS FROM:

*   Definitions from CRDC Manual
**   In County definitions
*** Partial Hospitalization Manual

**** CONREP State Manual

All other definitions from Short Doyle/Medi-Cal Manual for the Rehab Option Coordinated Services